Bundle Trust Board Meeting in Public 7 September 2023

1.1 10:30 - Agenda
Chair
1. Agenda Board Meeting in Public - 07.09.23 v 2
1.2 11:00 - Apologies
Chair
2 11:00 - Declarations of Interest
Chair
3 11:00 - Patient Story
Director of Patient Care and Chief Nurse - To Follow
4 11:00 - Minutes of the Last Meeting
Chair
4. Minutes Trust Board Meeting in Public 06.07.23 AD
5 11:00 - Matters Arising and Action Log
Chair
5. Board Action Log 06.07.23
6 11:00 - Chair's report
Chair
6. Chair's Report Coversheet Sept 2023
6.1 Chair's report
7 11:05 - Chief Executive's Report
Chief Executive
7.1 Elective Care Priorities Sept 23
7.2 BLMK ICB Report 7 September 2023 v3
8 11:20 - Serious Incident and Learning Report
Director of Corporate Affairs/ Medical Director
08. Front Sheet
08.1 SI Report for Board_IR
08.2 PSIRF pilot summary for Trust Board Sept 2023
9.1 11:25 - Maternity Assurance Group Update
Director of Patient Care and Chief Nurse
09.1 MKUH Sep 2023 MAG Coversheet
9.2 11:35 - Maternity Staffing Update
Director of Patient Care and Chief Nurse
09.2 Maternity Staffing Overview Trust Board Report September 2023 YC
09.2.1 App 1 - Escalation process for urgent Obs cons review if hot week consultant unavailable

09.2.2 Appendix 2 - Neonatal Workforce Tool MK Aug 2023

10 11:35 - Performance Report
Director of Operations

10. 2023-24 Executive Summary M04 Coversheet
10.1 2023-24 Executive Summary M04
10.2 2023-24 Board Scorecard M04 V2

11 11:45 - Finance Report
Director of Finance

11. Finance Report Month 4

12 11:55 - Workforce Report
Director of Workforce

12. Sept 23 Board Workforce Report M4

13 12:00 - Medical Revalidation – Statement of Compliance
Medical Director

13. MKUH Coversheet v September 2022 - NHSE AOA
13.1 Signed B1844 - Framework of quality assurance for responsible officers and revalidaton 22-23

14 12:05 - Emergency Preparedness Resilience and Response (EPRR) Annual Assurance Review 2023
Director of Operations

14. MKUH Core Standards Assurance 2023 Report - Cover
14.1 MKUH Core Standards Assurance 2023 Report v 2

15 12:10 - Risk Register Report
Director of Corporate Affairs

15. Trust Board - 7th September 2023 - Risk Register Report
15.1 Corporate Risk Register - as at 29th August 2023

16 12:15 - Board Assurance Framework
Director of Corporate Affairs

16. Board Assurance Framework August 23

17 12:20 - Summary Reports
Chair

17.1 Audit Committee Summary Report 17.07.2023
17.2 FIC 06.06.2023 Board Committee Summary Report
17.3 FIC 04.07.2023 Board Committee Summary Report
17.4 TEC Board Committee Summary Report 12.07.23
17.5 TEC Board Committee Summary Report 09.08.23
17.6 Charitable Funds Committee Summary Report 20.07.23

18 12:25 - Forward Agenda Planner
Chair

18. Trust Board Meeting In Public Forward Agenda Planner v

19 12:30 - Questions from Members of the Public
Chair

20 12:30 - Motion To Close The Meeting
Chair

21 12:30 - Resolution to Exclude the Press and Public
The chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business:
"That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."

22 12:30 - Close
Next Meeting in Public: Thursday, 02 November 2023

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10:30 am on Thursday 07 September 2023
in the Conference Room at the Academic Centre and via MS Teams

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10:30	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 • 2023 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 To Follow
4		Minutes of the Trust Board meeting held in public on 06 July 2023	Approve	Chair	Attached
5		Matters Arising and Action Log	Note	Chair	Attached
Chair and Chief Executive Updates					
6	11:00	Chair's Report	Information	Chair	Attached
7	11:05	Chief Executive's Report • Elective Care Priorities • BLMK Health and Care Partnership and Integrated Care Board Update	Receive and Discuss	Chief Executive	Verbal Attached Attached

Item No.	Timing	Title	Purpose	Lead	Paper
Patient Safety					
8	11:20	Serious Incident and Learning Report	Receive and Discuss	Director of Corporate Affairs/ Medical Director	Attached
Patient Experience					
9	11:25	• Maternity Assurance Group Update • Maternity Staffing Update	Receive and Discuss	Director of Patient Care and Chief Nurse	Attached Attached
Performance					
10	11:35	Performance Report	Receive and Discuss	Chief Operations Officer	Attached
Finance					
11	11:45	Finance Report	Receive and Discuss	Director of Finance	Attached
Workforce					
12	11:55	Workforce Report	Receive and Discuss	Director of Workforce	Attached
Assurance and Statutory Items					
13	12:00	Medical Revalidation – Statement of Compliance	Receive and Discuss	Medical Director	Attached
14	12:05	Emergency Preparedness Resilience and Response (EPRR) Annual Assurance Review 2023	Receive and Discuss	Director of Operations	Attached
15	12:10	Risk Register Report	Receive and Discuss	Director of Corporate Affairs	Attached
16	12:15	Board Assurance Framework	Receive and Discuss	Director of Corporate Affairs	Attached
17	12:20	(Summary Reports) Board Committees • Audit Committee 17/07/2023	Assurance and Information	Chairs of Board Committees	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		• Finance Committee 06/06/2023 and 04/07/2023 • Trust Executive Committee 12/07/2023 and 09/08/2023 • Charitable Funds Committee 20/07/2023			
Administration and Closing					
18	12:25	Forward Agenda Planner	Information	Chair	Attached
19		Questions from Members of the Public	Receive and Respond	Chair	Verbal
20		Motion To Close The Meeting	Receive	Chair	Verbal
21		Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and /move into private session to consider private business: "That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."	Approve	Chair	
12:30		Close			
Next Meeting in Public: Thursday, 02 November 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)
Joe Harrison	Chief Executive Officer	(JH)
Bev Messinger	Non-Executive Director	(BM)
Dr Dev Ahuja	Non-Executive Director	(DA)
Gary Marven	Non-Executive Director	(GM)
Mark Versallion	Non-Executive Director	(MV)
Dr Ian Reckless	Medical Director	(IR)
Danielle Petch	Director of Workforce	(DP)
Yvonne Christley	Director of Patient Care and Chief Nurse	(YC)
Emma Livesley	Director of Operations	(EL)
Daphne Thomas	Deputy Director of Finance (For Terry Whittle)	(DT)

In Attendance:

Kate Jarman	Director of Corporate Affairs	(KJ)
Jason Sinclair	Associate Non-Executive Director	(JS)
Emma Codrington	Associate Chief Nurse	(EC)
Diane Gray (item 3)	Neonatal Sister, Neonatal Unit	(DG)
James Biggin-Lamming	Director of Strategy and Transformation, London North West University Healthcare NHS Trust (Shadowing JH)	(JBL)
Anita Basudev	Admin Manager – Medicine (Shadowing JH)	(AB)
Kwame Mensa-Bonsu	Trust Secretary	(KMB)
Timi Achom	Senior Corporate Governance Officer	(JP)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting. There were apologies from Ganesh Baliah (Associate Non-Executive Director), John Blakesley (Deputy Chief Executive), Haider Husain (Non-Executive Director), Precious Zumbika-Lwanga (Associate Non-Executive Director), Heidi Travis (Non-Executive Director), and Terry Whittle (Director of Finance).

2 Declarations of interest

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

3 Patient Story

3.1 EC introduced DG who presented the journey of a patient and their family through (NNU) Neonatal Unit. The presentation included video of the parents explaining how they felt and what their experience was like during the weeks they attended the unit.

Baby C was born at 29+3 weeks (11 weeks early), and weighed 1500g, and was the parents' first pregnancy. EC explained the benefits of skin-to-skin bonding for parents and babies, including preterm babies, so they could become clinically more stable and promote brain development.

3.2 The baby was delivered by the father whilst on the phone to paramedics, at the side of the road. The father also had to perform mouth to mouth resuscitation with paramedics instructing him.

3.3 The parents felt that staff listened to them and addressed their concerns appropriately. Baby C spent 6 weeks at the Neonatal Unit and went home at 35+2 weeks,4 weeks before they were due to arrive.

3.4 DG advised of the process of sharing feedback from parents and engagement with parents through co-production projects such as cot boards and admission packs.

3.10 On behalf of the Board, AD thanked DG for the presentation.

4 Minutes of the Trust Board Meeting in Public held on 04 May 2023

4.1 The minutes of the Trust Board Meeting in Public held on 04 May 2023 were reviewed and **approved** by the Board.

5 Matters Arising

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

Action 24 Significant Risk Register
In progress. An update would be provided in September 2023.

Action 31 CQC Maternity Patient Experience Update
In progress. An update would be provided in September 2023.

Action 34 Delay around procurement and delivery of PCA (Patient-Controlled Analgesia) Pumps machines
Issue investigated and resolved. **Closed.**

There were no other matters arising.

6 Chair's Report

6.1 AD provided an update from the Inclusion Leadership Council meetings that had taken place recently. AD advised that the Council was receiving updates on the automation of the recruitment processes to gain assurance of the ease of use and fairness of access. AD also highlighted the non-mandatory LGBTQ+ learning pack available on e-learning and advised that all staff would be encouraged to do the training. Staff volunteers were also contributing to flash cards in various languages to help with immediate communications in, for example, the Emergency Department. A new 'Engagement Award' which recognised community coordination, engagement and working with Trust networks would be launched in the near future.

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

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

7.1.1 NHS@75 celebration
JH reported the NHS@75 celebration took place on 05 July 2023 and advised the celebrations went well with a significant number of staff participating.

Operational pressures
The organisation continued to experience operational constraints and June 2023 saw the highest number of ED visits recorded. Further industrial action by non-consultant doctors was planned for 13 July 2023 to 18 July 2023. This would result in some elective work being cancelled. Consultants strikes were also planned for 20 and 21July 2023. Mitigations were in place around ensuring a safe level of care was maintained during these strikes.

Staff awards
The yearly staff award took place on Thursday, 29 June 2023 with over 200 staff attending the successful event.

7.2 Following the CQC inspection visit to the Maternity Unit in March 2023, the inspection report had been received. The report provided the Maternity Unit with an overall rating of Good and an Outstanding rating for Well-Led. In response to this, YC advised the Board of the continuous improvement and actions being undertaken by Maternity. She stated that a three-year delivery plan was released on 30 March 2023, with a detailed programme to support the delivery of the plan's actions. YC also advised that a gap analysis had taken place for the Clinical Negligence Scheme for Trusts (CNST) which was released on 31 May 2023 to ensure Maternity Unit continued to maintain the highest safety ratings.

7.3 JH stated that the NHS Workforce plan had been published and advised the NHS was getting an additional £2.4 billion into its budget.

7.4 In response to MV's query around whether the BLMK ICB would consider proposing any changes to the Target Operating Model, JH stated that the Model was out for consultation.

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

8 Serious Incident and Learning Report

8.1 IR presented the report and advised that the report indicated a low reporting quarter which was reflective of the Patient Safety Incident Response Framework (PSIRF) approach to assessing incidents with a focus on learning, and consideration of other quality improvement projects.

8.2 IR highlighted the following as part of his overall report:

1. All NHS organisations were mandated to transition over to PSIRF by Autumn 2023 with the Trust sharing its PSIRF plan and policy would be signed off by the Quality and Clinical Risk Committee in September 2023.
2. A response had been provided to the HM Coroner around the regulation 28 report/ Prevention of Future Death (PFD) for case MK 2649. The response and plan would be shared at the Quality and Clinical Risk Committee in September 2023.

8.3 In response to AD's request for an update on the suboptimal head and neck cancer pathway, IR informed the Board that talks to move this service from Northampton General Hospital to the Oxford University Hospitals was in progress.

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

9 Performance Report for Month 02 (May 2023)

9.1 EL presented the Performance Report for Month 02. There were 4 C.Difficile infections reported in the Emergency Department (ED) and ambulance handovers saw a slight decrease in May 2023. The cause for this was being investigated. Outpatients saw an improvement in the rate of Did Not Attend (DNAs) although this was still below National target.

9.2 From an elective performance position, EL reported that the challenge set for the end of the year was clearance of 78-week patients however, the Trust had not managed to achieve this due to industrial action, capacity, and complexity of patient choice. Diagnostics was showing an improving performance, but below National target and the number of escalation beds remained high.

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

10 Finance Report for Month 02 (May 2023)

10.1 DT reported a cumulative deficit of £4 million having recorded a £2 million deficit in April 2023 and a further £2 million in May 2023; noted this was £4.2 million worse than the approved plan. Several urgent measures were in place to reduce the cost run rate and close the gap between income and expenditure.

10.2 The efficiency target for 2023/24 was £17.3m, which equated to around 5% of expenditure for 2023/24. The targets had been split out to divisions and were based on controllable spend. Focus remained on closing the gap and measures including eliminating agency cost, and improvement of open escalation beds was in place.

10.3 The year-to-date (YTD) capital spend to the end of May 2023 was £7.5 million which was £0.5 million below the approved YTD plan. The Trust ICS CDEL approved allocation was short by £5 million of the Trust's £18.3m submitted plan for ICS CDEL and constructive discussions around this was ongoing with NHS England

10.4 The 2022/23 accounts and annual report had been signed off by the Auditors following submission of accounts by required date of the 30 June 2023. The Accounts and Audit report would be tabled at the Private Board on 06 July 2023.

10.5 The Board **noted** the Finance Report for Month 02.

11 Workforce Report for Month

11.1 DP highlighted the following from the report.

1. Temporary staffing usage has remained around 14% for the past 6 months. Work continued to ensure scrutiny of all agency spend.
2. The Trust's headcount for substantive staffing continued to increase with an additional 302 staff in post compared to the same period in the previous year and, despite an increase in budgeted establishment, the vacancy rate has continued to fall and is currently at 4.7% with improvements across several staff groups.
3. Staff absence had reduced to 3.9% in month 02 with a sustained improvement on short-term absence rates.
4. Staff turnover continued to make small improvements with a decrease down to 14.9%, its lowest point since August 2022.
5. The HR Services Team are planning to roll out a Freedom to Speak Up App which would create an easy and anonymous solution to raising concerns through the FTSU Guardian and Champion Team.
6. 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.

11.1 The Board **noted** the Workforce Report for Month 02.

12 Annual Claims Report

12.1 IR reported that the national total payments involved in NHS Resolutions clinical schemes was approximately £2.2 billion in financial year 2020/21.
The cost of Clinical Negligence Scheme for Trusts (CNST) claims incurred as a result of incidents in 2020/21 was £7.9 billion. NHS Resolution had advised that 60% of this cost related to maternity services.

12.2 The Board **noted** the Annual Claims Report

13 Antimicrobial Stewardship Annual Report

13.1 The Board **noted** the Antimicrobial Stewardship Annual Report

14 Falls Annual Report

14.1 YC presented the report and highlighted the Falls Prevention and Management Improvement Programme being implemented by the Trust.

14.2 The Board **noted** the Falls Annual Report

15 Hospital Acquired Pressure Ulcers Annual Report

15.2 YC reported there had been a significant decline in Hospital Acquired Pressure Ulcers which reflected improvements in data reporting and approach to the management of pressure ulcers in the hospital, and a detailed improvement programme in terms of education and comprehensive audits in the prevention of management pressure damage in ward areas.

15.3 The Board **noted** the Hospital Acquired Pressure Ulcers Annual Report

16 Freedom to Speak Up Annual Review

16.1 DP reported that 41 concerns were raised through Freedom to Speak up in 2022 and they were all addressed appropriately by the Freedom to Speak up Guardians.

16.2 The Board **noted** the Freedom to Speak Up Annual Review Report

17 Risk Register Report

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

18 Board Assurance Framework

18.1 KJ highlighted Risk 1 (staffing levels) and Risk 5 (suboptimal head and neck cancer pathway). She advised Risk 1 had been revised downwards from 15 to 10 due to increased staffing numbers in the Trust and commentary on the Risk 5 had been updated to indicate there were ongoing delays in Oxford University Hospitals (OUH) providing a response to NHS England on the potential way forward and the suboptimal process in terms of collaboration/engagement with the Trust on the proposed service model.

18.2 The Board **noted** the Board Assurance Framework

19 Board Committees Summary Reports

19.1.1 Summary Report for the Audit Committee – 18 April 2023, 25 May 2023, and 23 June 2023.

19.1.2 The Board **noted** the reports.

19.1.3 Summary Report for the Finance and Investment Committee Meeting – 7 March 2023, 4 April 2023, and 2 May 2023.

19.1.4 The Board **noted** the reports.

19.1.5 Summary Report for the Trust Executive Committee – 8 March 2023, 10 May 2023, and 14 June 2023.

19.1.6 The Board **noted** the reports.

19.1.7 Summary Report for the Quality & Clinical Risk Committee – 12 March 2023 and 5 June 2023.

19.1.8 The Board **noted** the reports.

19.1.9 Summary Report for the Charitable Funds Committee – 16 February 2023 and 17 April 2023.

19.1.10 The Board **noted** the report.

19.1.11 Summary Report for the Workforce and Development Assurance Committee – 18 May 2023.

19.1.12 The Board **noted** the report.

20 Use of Trust Seal

20.1 The Board **noted** the use of the Trust Seal.

22 Forward Agenda Planner

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

23 Questions from Members of the Public

23.1 There were no questions from the public.

24 Any Other Business

25.1 There was no other business.

26 The meeting closed at 11:50

Updated : 18/08/23

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	07-Sep-23	To be progressed after the Trust's Risk Appetite Statement has been reviewed. In progress. An update would be provided in September 2023 after the Audit Committee Risk Seminar .	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	07-Sep-23	Presentation to October 2023 Board Seminar	Open

Meeting Title	Trust Board of Directors	Date: 07/09/2023
Report Title	**Chair's Report**	**Agenda Item Number: 6**
Lead Director	Alison Davis, Chair	
Report Author	Alison Davis, Chair	

Introduction	Standing Agenda Item		
Key Messages to Note	An update for the Board on activity and points of interest including: • MKUH has been awarded the Gold Award under the Armed Forces Covenant • The Neonatal services have achieved the Unicef Baby Friendly Stage 1 accreditation.		
Recommendation *(Tick the relevant box(es))*	**For Information** x	**For Approval** ☐	**For Review** ☐

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

Report History	*N/A*
Next Steps	*N/A*
Appendices/Attachments	*Report*

Chair's report: September 2023

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

1. The annual Staff Awards took place on the 29th June and was well attended; a very enjoyable evening. There were hundreds of nominations this year from members of staff and patients in the different categories, identifying again the many areas of individual and team excellence.

2. MKUH celebrated the 75th birthday of the NHS on the 5th July with morning and afternoon tea sessions and the sharing of a spectacular cake prepared by our catering manager Frank Fiore.
   The 'icing on the cake' for the day was the announcement of maternity services CQC ratings, which were Good overall and Outstanding for leadership. There was a celebratory breakfast to thank the team for their hard work and commitment to delivering high quality services.

3. The Board completed the second part of its training with Above Difference; Leading and Engaging with Cultural Intelligence. The ambition now is to have the learning rolled out across all areas of the organisation.

4. Work with Arts for Health MK is continuing, improving courtyard areas and planning for patient and staff engagement, as well as exploring possible revenue sources to fund future projects.

5. On the 17th August Joe Harrison unveiled the 'Veteran Aware' Plaque in the main reception of the hospital (a purple tick sign just to the left of the reception desk).
   Having signed up to The Armed Forces Covenant only two years ago, the Trust has achieved the Gold Award under the scheme demonstrating its commitment to the care of veterans and serving personnel in our patient and staff populations. Thanks must go to Johanna Hrycak, our Armed Forces Covenant Support Officer, for the huge amount of work and drive she has put into the scheme, enabling the Trust to achieve this recognition so quickly.

6. On the 24th August the Neonatal Team heard they had achieved Unicef Baby Friendly (BFI) stage 1 accreditation. Congratulations to Paulette Jasi and the Neonatal Feeding Team for their hard work and thanks to all those who supported them across the Trust.

The following document may be of interest, coming out of a review by the NHS Assembly on the 75th Anniversary of the founding of the NHS:

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

Meeting Title	Trust Board	Date: 6th September 2023
Report Title	**Elective Care Priorities**	**Agenda Item Number: 7**
Lead Director	*Emma Livesley* *Director of Operations*	
Report Author	*Emma Livesley* *Director of Operations*	

Introduction	*NHSE are seeking assurance against the Elective Care Priorities.*		
Key Messages to Note	*The Trust is undertaking a self-certification exercise to improve Outpatient activity. The main areas of focus include; validation, first appointments and outpatient follow-ups.*		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Review** x

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

Report History	*n/a*
Next Steps	*Trust Board is asked to delegate the review and sign off, of the Checklist to the Finance and Investment Committee (FIC) before submission on 30th September 2023.*
Appendices/Attachments	*Report*

Elective Care Priorities - Self Certification by Trust Board

September 2023

1. Introduction

NHSE has recently written to all acute providers seeking Trust Board assurance in Elective Care, specifically Outpatients. National toolkits and evidence based practical guides are being supplied by NHSE to support this work. A self-assessment checklist has been issued by NHSE and has been completed.

The Board is asked to receive and review the checklist and the Trust's current position against the self-certification process before submission to NHSE by 30th September 2023. A detailed update will be provided to Finance and Investment Committee (FIC), prior to 30th September submission.

2. Protecting and expanding elective capacity.

Protecting and expanding elective capacity letter was received from NHSE on the 7th August. This correspondence highlighted the need for more focussed transformational work on Outpatients and set out the need to increase the pace in transforming outpatient services. The ask is to release existing capacity for patients awaiting their first contact and diagnosis, ahead of and during winter, when pressure on inpatient beds is recognised at its highest.

The updated priorities are defined as follows:

a) Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
b) Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.
c) Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

Board assurance and self-certification again is being sought in the following areas:

- Validation
- First appointments
- Outpatient follow-ups

3. Self- certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. Trusts are asked to complete this return to provide assurance on these recovery plans.

Trust return: Milton Keynes University Hospital

The chair and CEO are asked to confirm that the board:

Assurance area	Assured?
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality.	Current validation 35%. Improvement plan developed to move to 90% Access Policy has been updated and approved. Trust wide training programme for clinical and administration staff in place.

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	Action delegated to FIC
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers.	Plan in place to achieve. Trust Board has agreed minimal use of ISP this year, given financial challenges.

3. Outpatient follow-ups The board:	
a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	Planning submission acknowledged the challenge. National support being requested.
b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits.	Developing improvement plan.
c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024.	Current performance is 5.9%
d. has a plan to increase use of specialist advice.	No - support being requested
e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	Divisional transformation plans in place and development of eCare OPD work flow.

4. Support required	
The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	To be agreed

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Date7 September 2023

ICB Executive Lead: Felicity Cox, BLMK ICB CEO
ICB Partner Member: Joe Harrison CEO, MKUH

Report Author: Michelle Evans-Riches Acting Head of Governance BLMK ICB

Report to the: Milton Keynes University Hospital Trust Board

Item: – **Bedfordshire, Luton and Milton Keynes Health and Care Partnership and Integrated Care Board update**

1.0 Executive Summary

1.1 This report summarises key items of business from the BLMK Integrated Care Board and BLMK Health and Care Partnership (a Joint Committee between the local authorities and the ICB) that are relevant to the Milton Keynes University Hospital Trust.

2.0 Recommendations

2.1 The Board are asked to **note** this report.

3.0 Key Implications

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

3.1 This report addresses resourcing and equality and inequalities in terms of inequalities funding. Equality /health inequalities and engagement are also addressed in the update on health and employment seminar. The Joint Forward Plan sets out the ICB's green plan commitments.

4.0 Report

4.1 The Board of the ICB met on 30 June, the communications from the meeting are attached at Appendix A and key areas of note are as follows:

4.1.1 Denny Review

The Denny Review into Health Inequalities across Bedfordshire, Luton and Milton Keynes will be published in September 2023 and will be available on Bedfordshire Luton and Milton Keynes ICB website here. It is a landmark study that will guide work over the next five years and beyond, with its findings embedded in everything the Integrated Care Board, and wider Integrated Care System, does.

For the last three years, Reverend Lloyd Denny from Luton has been working with health and care partners and residents in all four places to undertake a root and branch review of health inequalities. The review sought to understand:

- Which communities in our area experience the greatest health inequalities;
- What the barriers are in this and other communities to accessing health and care services;
- What the lived experiences of health inequality are; and
- How we can remove barriers, improve experience and support good health.

Partners from local authorities, public health, Healthwatch, the VCSE, University of Bedfordshire and the NHS came together to agree the foundations for the study, anchor it into existing work programmes and, based on Revd Denny's fundings, support the development of the final report and its recommendations.

A Literature Review from the University of Sheffield analysed all published material about health inequalities in BLMK, and identified the populations most affected by health inequalities. These included Gypsy, Roma and Traveller communities, people who live in deprived neighbourhoods, people with learning and physical disabilities, people who experience homelessness, migrants, and LGBTQ people.

Based on these insights, population health data was used to map where the health inequalities were most prevalent in our four places, and our four Healthwatch organisations and the VCSE partners lead engagement with different communities to understand in depth the lived experiences of these seldom-heard groups.

On publication of the reports, a Quality Improvement approach was developed to analyse feedback and develop recommendations.

From the interviews and surveys undertaken with hundreds of residents, four main themes emerged:

- the accessibility of services;
- communication and language;
- culture/faith and the cultural competency of health and care organisations; and,
- unconscious bias, homophobia and racism.

Analysis established that the absence of a person-centred approach to health and care risks widening and entrenching health inequalities as people feel that services are "not for them".

Reverend Lloyd Denny will publish his independent report in mid-September, setting out the recommendations based on the insights gathered. The ICB will then provide a formal response to outline how the recommendations will be taken forward.

The ICB looks forward to the publication of the report and to working with all Places and Partners, including Revd Denny, to take forward the recommendations, and to making available resources to do this successfully.

Our ambition is clear: the findings of the Denny Review findings must be well understood across BLMK, and recommendations taken forward, with partners, to support people from <u>all backgrounds</u> to live longer lives in good health.

4.1.2 **Health Inequalities funding** – The Board agreed a paper which included approval of the allocation of £500K to each of the four places in BLMK for the current year (2023/24) 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.

4.1.3 **BLMK Joint Forward Plan** – The Board formally approved the Joint Forward Plan for 2023-2040 following extensive engagement with partners. The report has been published onto the BLMK Health and Care Partnership website (here).

4.1.4 **Memorandum of Understanding with Healthwatch** – A Memorandum of Understanding between the ICB and Healthwatch was approved, recognising the important role that Healthwatch has as a strategic partner to the ICB. It also reflects the important role Healthwatch has in representing the resident voice, as well as their statutory function.

4.1.5 **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 (Central Bedfordshire and Bedford Borough S.75 agreements are due to be considered at the ICB Board on 29 September 2023).

4.1.6 **BAF Risks -** Ten BAF risks were reported to the Board (see below), BAF0010 is new following review by SOAG. Due to the impact of ongoing industrial action, there have been changes to the likelihood of a number of risks as illustrated below.

Ref	Risk Title	Risk Description	Current Risk Rating	Change
BAF0001	Recovery of Services	There is a risk that the NHS is unable to recover services and waiting times to pre-pandemic levels due to Covid related pressures, or demand led pressures. This may lead to poorer patient outcomes and reputational damage.	20	↑
BAF0002	Developing suitable workforce	If system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce then staff experience, resident outcomes and the delivery of services within the ICS, ICB People Responsibilities and the System People Plan are threatened.	20	=
BAF0003	System Pressure & Resilience	As a result of continued pressure on services from various factors (staff sickness, increased activity etc) there is compromised resilience in the system which threatens delivery of services across BLMK.	20	=
BAF0004	Widening inequalities	There is a risk that inequalities in the system widen due to a range of factors leading to compromise to population health and increases in system pressure in the most deprived areas.	20	↑
BAF0005	System Transformation	There is a risk that as a result of significant operational pressures, there will be decreased capacity to focus on strategic transformational change to deliver improved outcomes for our population.	20	↑
BAF0006	Financial Sustainability and Underlying Financial Health	As a result of increased inflation, significant operational pressures, elective recovery and the enduring financial implications of the covid pandemic - there is a risk to the underlying financial sustainability of BLMK that could result in failure to deliver statutory financial duties.	20	↑
BAF0007	Climate Change	Due to climate change and wider impacts on the environment and biodiversity, there is a significant risk of increased pressure on health and care services.	16	=
BAF0008	Population Growth	As a result of fast rate of population growth in BLMK, there is a risk that our infrastructure will not keep pace with the needs of our population, resulting in poor health and wellbeing for residents.	20	=
BAF0009	Rising Cost of Living	As a result of rising cost of living there is a risk that residents will not be able meet their basic needs resulting in deteriorating physical and mental health resulting in pressure on all public services.	16	=
BAF0010	Partnership Working	There is a risk that the development of the ICS's public position on an issue is inconsistent with the public position of one or more partner member, resulting in a lack of clarity for the public and stakeholders.	12	NEW

The mitigations to the Partnership Working risk (BAF0010) are being reviewed following discussions regarding the inequalities funding and an assessment of the risk related to the challenges faced by residents accessing and navigating the system will be undertaken and reported to the next Board.

4.2 **Health and Employment Seminar 21 July**– the first joint seminar of the BLMK Integrated Care Board and Integrated Care Partnership took place on 21 July 2023

and around 80 people from local authorities, the NHS and other public services, including the Prison Service and the Department for Work and Pensions, were joined by representatives of the voluntary, community and social enterprise sectors for a day of action planning on tackling poor health to improve employment outcomes for residents. Danielle Petch, Director of Workforce and Sue Milner attended for MKUH.

Attendees also included residents with relevant lived experience, several of whom shared powerful stories of the positive health impact of finding employment.

A **2022 study by the Health Foundation** found that unemployed people were more than five times as likely as those in employment to be in poor health, whilst **NHS figures from 2021** indicate that people with a long-term condition have an employment rate of 64.5%, compared with 75% of the population as a whole, a gap of 10.5%. The employment gap is even wider in Luton (16.1%) and Central Bedfordshire (14.4%).

The event's keynote speaker, Professor Donna Hall CBE, is chair of the community-focused think tank New Local and an advisor on Integrated Care Boards to NHS England. She was formerly chief executive at Wigan Council.

Detailed planning sessions were held throughout the afternoon, with individual group discussions for Bedford Borough, Central Bedfordshire, Luton and Milton Keynes, to identify key priorities and agree actions that will be taken forward by those working at Place, with support from the ICB. A summary of the discussion and action planning is attached at Appendix B, with Milton Keynes Place group actions detailed on slides 33-39.

The next programmed joint seminar is on 24 November 2023 and will focus on Children and Young People and the ICS Strategic Priority 'Start Well'.

4.3 **Specialised commissioning**

An extra-ordinary meeting of the ICB Private Board took place on 28 July to discuss the delegation and hosting of 59 specialised commissioning services which will be delegated to ICBs from 1 April 2024. The specialised commissioning services are the more high-volume specialised services that affect a good proportion of the population (e.g. chemotherapy/radiotherapy, dialysis). NHSE is retaining the low volume and high complexity services and it is not known if it is planned to delegate the responsibility for these services in future.

BLMK does not have a tertiary provider in its area (although both MKUHFT and BHFT do provide some specialised services) and this affects access to the services and outcomes for our residents. The East of England is also the NHSE region with the lowest spend on specialised services, which may suggest that our population are not benefitting as much as they could be from these services. The delegation of services provides a real opportunity to bring services closer to home where clinically appropriate and increases the ability to influence decisions on service provision and financial investment.

The Board supported the ICB hosting of specialised commissioning in the East of England in a joint venture with other ICBs in the region and NHSE, subject to certain conditions and assurances.

5.0 Next Steps

None

List of appendices – Appendices available on request

Appendix A – ICB Board 30 June 2023 communications.
Appendix B – Health and Employment Seminar 21 July summary

Background reading

None

Meeting title	Trust Board	Date: 7 September
Report title:	Serious Incident and Learning Report	Agenda item: 8
Lead director Report author Sponsor(s)	Dr Ian Reckless Kate Jarman	Medical Director Director of Corporate Affairs
FoI status:	Public document	

Report summary	Serious incident and learning report – serious incidents and key patient safety issues within the reporting period.							
Purpose *(tick one box only)*	Information	☐	Approval	☐	Discussion	x	Decision	☐
Recommendation	For comment.							

Strategic objectives links	Patient safety
Board Assurance Framework links	
CQC regulations	All
Identified risks and risk management actions	None identified
Resource implications	None identified
Legal implications including equality and	None identified

diversity assessment	

Report history	Regular reporting
Next steps	Quality and Clinical Risk Committee
Appendices	1. Serious Incidents Report 2. PSIRF Phase 1 Pilot Initiation and Summary

This report provides and overview of patient safety incidents, themes, issues and learning in the reporting period July and August 2023.

Serious Incidents July to August 2023

Ward 17	Medication incident: Insulin administered incorrectly
Emergency Department Majors (ED)	Flagged for review under the sepsis improvement programme: Patient presented with acute epigastric/abdominal pain. Previous history of gallstones. CT angiogram aorta to rule out aortic dissection and noted to have gall stones. Pain improved post intravenous morphine. Patient discharged with pain relief and oral antibiotics. Patient presented two days later with cholecystitis with possible perforation during surgery.
Ward 2B	Patient fall
Angiography Unit	Infection control: MRSA
Maternity Triage	Maternity / Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant)
Emergency Department Majors (ED)	Sub-optimal care of the deteriorating patient meeting SI criteria
Maternity	Category 1 C-section
Emergency Department	Delay in reporting blood gas
Medicine	Medication error: Gentamicin

Incidents in 2022 and 2023 - Choking/ Aspiration

In the last 12 months, three incidents have occurred where patients have or appear to have choked or aspirated on food and sadly died. There is no trend in location. All three incidents involved vulnerable patients – two with learning difficulties and one who was clinically frail.

Each incident was investigated – one with a SAFE review under the new Patient Safety Incident Response Framework – with action plans for specific wards.

Additionally, the Trust input from Central North West London NHS Foundation Trust for a systemic programme of work and review of current practice. The Trust is piloting an Eating and Drinking At Risk programme, which begins this month

(September 2023) across all inpatient medical and surgical wards. This includes a new policy, patient literature and a patient passport flagging the patient as potentially 'at risk' whilst eating or drinking. This focuses on staff awareness as well as empowering patients, families and carers with shared information and understanding of risk to support multi-disciplinary clinical plans and care.

The cases are summarised below:

Incident Date	**Ward**	**Summary**	**Inquest Date and Verdict**
28 June 2022	3	A 72-year-old gentleman with Parkinson's Disease. Admitted following discharge from another hospital, having been treated for sepsis. Patient's wife reported patient choking. Patient found to have food obstructing his airway.	4 September 2023 Verdict: Accident
14 July 2022	20	A 60-year-old gentleman with learning difficulties, autism and a significant medical history. Underwent surgery for a bowel obstruction. Recovering from surgery, with a soft diet prescribed. Patient found unresponsive shortly after mealtime, having choked on his food.	27 and 28 April 2023 Verdict: Narrative HM Coroner recommended Trust improve communication with the families of vulnerable adults
24 June 2023	Ward 14	Patient with learning disabilities admitted from residential care for acute medical care with complex medical history. Family raised concern that patient had food and medication in his mouth, which they cleaned. Patient deteriorated and died on 28 June. Cause of death recorded as aspiration pneumonia.	Inquest scheduled later in 2023

Incident Themes

- Pressure ulcers (more community than hospital acquired).
- Discussion in relation to feeding at risk/ vulnerable patients.
- Handover and communication about required diets for patients to ensure all staff aware.

- Complications post endoscopic procedures (two cases referred to HM Coroner) including the required observations on wards for day cases subsequently admitted for 'close monitoring' and what this means.

- The importance of including risks as part of the consent process and ensuring patients understand and can weigh up those risks.

- Extravasation injuries - audit undertaken and from that a template has been created for completion in the event of an extravasation incident. This can then be used to record the details of the event and provide advice to patients.

- Clarity of requests to the ambulance service in relation to types of emergency transfers to enable correct service within expected time frame.

Shared Learning from Incidents

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

1. **Medication**

   The potential risk of errors when prescribing and administering medications that we are less familiar with. Please remain vigilant when prescribing or administering any medication that you have never done before or don't do very often. There are many ways to help make this process safer for our patients:

   - Request an independent second check when administering these medications. Check out this video for further guidance.
   - Seek the advice from your ward pharmacist (or the on-call pharmacist out of hours)
   - Contact the medicines advice service via information.medicines@mkuh.nhs.uk or ext 85733

2. **Falls**

   Many patients in our care, or visiting the hospital, may be at risk of falls, or are observed as being unsteady on their feet. This could include patients who are visiting the hospital for outpatient appointments/clinics.

   - How safe are our environments?
   - Are they free of trip hazards?
   - Do patients have a way to seek help or get attention without the need to get up and mobilise?
   - How can we effectively communicate any falls risks between teams in the hospital and those providing transport?

3. **Eating and Drinking**

   What have you found is the best way to share the dietary status of patients on your ward amongst your teams? For example, nil by mouth, soft diet, thickened fluids, etc. Recent incidents have shown how important it is that our full team, including patients and relatives, understand the importance of what, and why, patients are allowed to eat and drink.

Reporting Rate

The reporting rate (number of incidents reported on Radar) has been closely monitored as part of an improvement programme to increase reporting – particularly of low harm, no harm or near miss incidents. Evidence suggests that higher reporting numbers are a positive indicator for safety culture – encouraging staff to report, learn from and prevent harm. The graph below shows the reporting rate over time and the impact of improvement work in Radar and the Trust’s work with NHS England to improve the new national reporting form. It is of note that the Trust remains one of the only organisations to use the NHS England PSIRF incident form in the country – its roll out delayed with feedback about its length and complexity. The Trust has been using the form since the implementation of Radar – the change in and recovery of incident reporting numbers can clearly be seen below.

Regulation 28 Report

The Trust received an unexpected Regulation 28 Report from HM Coroner in August.

The conclusion of the inquest reads as follows: Narrative Conclusion - Died as a result of a haemoperitoneum after insertion of a PEG tube, that is a recognised complication of a necessary medical procedure.

The matters of concern are as follows: (brief summary of matters of concern) That once the PEG tube was inserted at Milton Keynes Hospital it seems that the deceased's deteriorating condition was not monitored closely even though he was complaining of abdominal pain soon after the procedure was completed. His concerns were not escalated to a senior doctor for consideration of a possible bleed. The procedures and protocols following PEG insertions should be reviewed.

The Trust will respond in full to HM Coroner.

Transition to the Patient Safety Incident Response Framework

The Trust has been piloting the new PSIRF approach to investigation in three clinical areas. An overview is provided in the PowerPoint sides appended to this report. A consultation with the Clinical Governance Department has just concluded, which reorganises roles to better match PSIRF and the Trust’s commitment to both patient safety and quality improvement. This reorganisation better aligns roles and resources to specialist safety roles, and to the functions of clinical audit, workplace risk and improvement and learning.

PSIRF Phase 1 Pilot Initiation and Summary

QIP Topic : Patient Safety Incident Response Framework (PSIRF) **QIP Trigger:** Transition to PSIRF Autumn/Winter 2023

Project Leads:	Anna O'Neill, Anna Costello, Jacqueline Stretton, Tina Worth	Project Sponsors:	Ian Reckless and Kate Jarman

Project Aim:

In preparation for the transition to the new PSIRF, this pilot is an opportunity to test the new incident process in its totality, from triage through to safety action and improvement development and closure.

Project objectives:

1. To understand the volume of incidents requiring the different levels of response in accordance with PSIRF plan
2. To test the triage process in terms of time taken, membership, time of day, roles & responsibilities, decision making processes and data capture
3. To test the PSIRF toolkit (various response types and templates, i.e., Hot Debriefs, After Action Reviews, MDT Learning Events, PSII)
4. To gather feedback from stakeholders (ward staff, patients/families, governance, safety, QI team members, corporate nursing, SIRG members)
5. To understand resources and skills/training required for wider roll out of PSIRF
6. To explore new ways of working between patient safety, QI and divisions

Project Milestones

	Milestones	Date due
1	**Phase 1**: Initial 4-week pilot on ward 1, ward 23 and imaging department commencing 19 June 2023	14 July 2023
2	Continuation of **Phase 1** from 15 July 2023	29 Sept 2023
3	Planning for **Phase 2** to include the Emergency Department and a focus on divisional oversight of incident triaging, learning responses and ownership of safety actions.	2 Oct 2023
4	Development of the PSIRF policy and plan detailing the processes for incident triage, oversight and learning / improvement (for agreement at **Patient Safety Board)**	20 Sept 2023

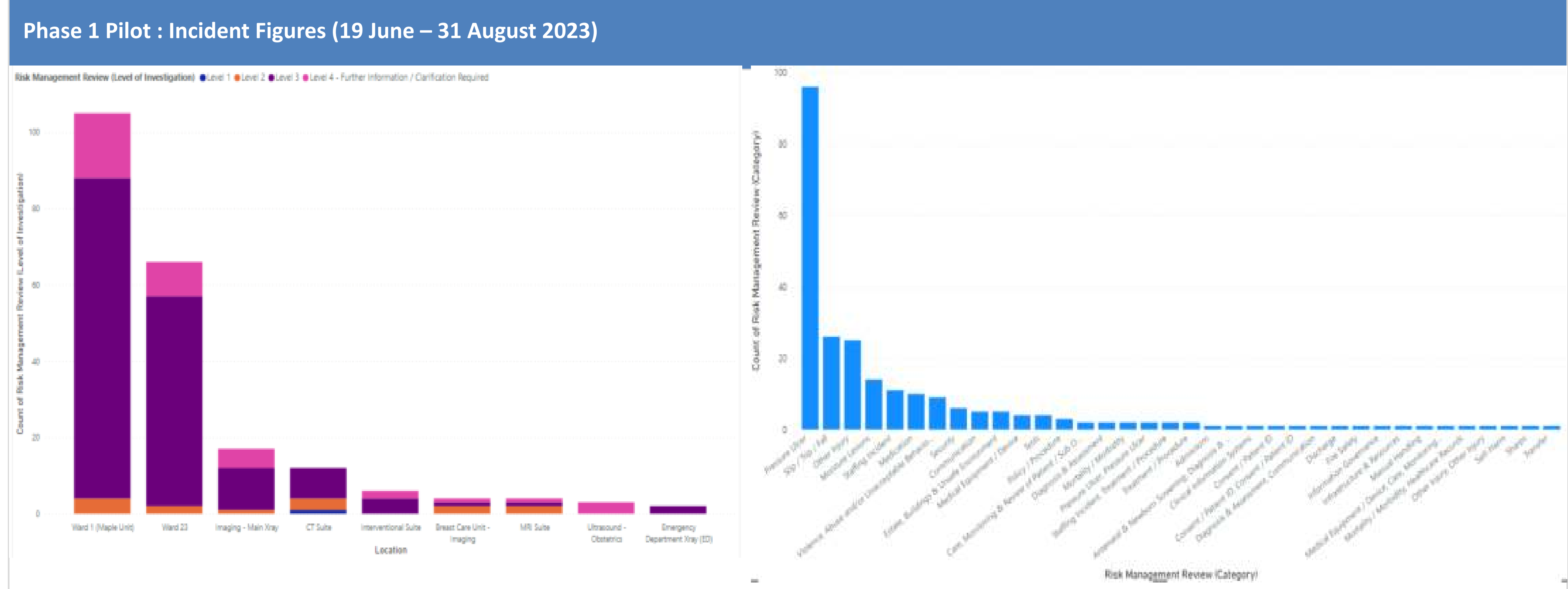
Identified Risks/Issues

	Risk / issue	Mitigation
1	Covering the triage and response rota centrally as a patient safety team	Reduced the triage and response cover from 4 for triage to 3 and 3 for response to 2
2	Risk of duplication of responses / confusion with other review processes (e.g., complaints, coroner)	Current cases discussed at SIRG and with relevant stakeholders for further guidance and agreement. Focus groups developed to review current processes for oversight roles and responsibilities
3	Staff familiarisation with the process and PSIRF toolkit	As part of the comms/training plan, a TNA has been developed which outlines key skills. Training will be delivered in house and will incorporate individual coaching sessions

PSIRF Phase 1 Pilot Initiation and Summary

QIP Topic : Patient Safety Incident Response Framework (PSIRF) **QIP Trigger:** Transition to PSIRF Autumn/Winter 2023

Phase 1 Pilot : Incident Figures (19 June – 31 August 2023)



Summary of activities

- **227** incidents triaged (19 June – 31 August)
- Average triage time = initially 5.8 mins/case, now 3.3 mins/case
- **3-5 members** on the panel each day (Patient safety, QI, Governance, Pharmacy, Risk, Nursing, Medical)
- **Level 3's** accounted for 73% of all incidents triaged

- 2 PSIIs (full patient safety incident investigation)
- 1 New audit commenced
- 6 thematic analysis
- 4 After Action Reviews

- 2 Hot Debriefs
- 2 MDT Learning Events
- 1 Structured Judgement Review (SJR)

PSIRF Phase 1 Pilot Initiation and Summary

QIP Topic : Patient Safety Incident Response Framework (PSIRF) **QIP Trigger:** Transition to PSIRF Autumn/Winter 2023

	Successes for sharing
1	Been able to identify trends for further learning/investigation (e.g., extravasation injuries, discharge medications) and learning for sharing through Spotlight On Safety (SOS)
2	Good involvement and engagement with the family as part of the first PSII completed
3	Staff involved in incidents have found the approach supportive and appreciated the focus on learning rather than blame
4	Reduced silo working by encouraging MDT learning with the safety team
5	Potential to screen off pressure ulcers and falls (levels 3) which account for over 68% of all incidents
6	Administrative support at triage has eased workload for response team
7	Great support and guidance from one another in the patient safety team (covering the rota, testing tools)
8	Templates developed for personal email responses for reporters
9	MDT representation at triage offers oversight and expertise (pharmacy, medical, nursing)
	Lessons Learnt
1	Practicality of running learning responses in a timely manner that works for those people involved
2	Immediate support and learning is taking place on the ward/department but requires more detailed work to identify how this is being captured
3	National PSII template repetitive and required local adaptation
4	Some inconsistency with triage practices that will need to be agreed before transition

Transition Phase - Next Steps:

- Develop a Trust wide process for the daily triage of patient safety incidents that supports divisional oversight and ownership in collaboration with a central patient safety and QI team.
- To review local and corporate oversight and assurance groups/boards to support the divisional ownership of patient safety incident triage, response and learning for improvement.
- Align job roles and responsibilities to the PSIRF plan and policy.
- Develop and provide necessary training to support the transition and embedding of PSIRF principles, tools and skills.
- Align incident review with other processes and events such as complaints, coroner reviews, SJRs, mortality reviews.

Meeting Title	Trust Board	Date: September 2023
Report Title	Maternity Assurance Group	Agenda Item Number: 9.1
Lead Director	Yvonne Christley - Chief Nurse, Board Level Maternity Safety Champion	
Report Author	Emma Mitchener – Deputy Head of Midwifery	

Introduction	The Maternity Assurance Group (MAG) was formed following the publication of the Final Ockenden Report to act as a formal reporting mechanism to the Trust Board. MAG monitors, reviews, and assesses maternity services to ensure high-quality patient care, safety, and clinical effectiveness.
Key Messages to Note	The areas discussed and reviewed at MAG for July 2023 are summarised below: Standing items included the following: • The Maternity Governance Report • Perinatal Quality Surveillance Model updates • Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme Year 5 • Ockenden Assurance MAG received the following quarterly reports: • Quarterly PMRT Report MAG received a quarterly update on the Perinatal Mortality Review Tool (PMRT). PMRT aims to support objective and standardised reviews (up to 28 days post-birth). The quarterly PMRT report overviews PMRT cases, learning and actions. The MDT reviewed 4 cases to identify themes. Future work will include partograms, obstetric ultrasound and CO monitoring improvements. • Maternity Experience Report MAG received a quarterly update on maternity experience relating to maternity service user experience. Maternity experience feedback is reported monthly in Women's CSU and monitored through the Patient Experience Board. A task-and-finish group with the Maternity Voices Partnership reviews feedback and improvement. A maternity service user experience lead midwife is now in post and will support with the maternity experience. The focus of improvement activity has been bookings, self-referral translation services, postnatal discharge packs and the personalisation of bed spaces. • Avoiding Term Admissions into Neonatal units (ATAIN) and Transitional Care Report MAG received a quarterly report for neonatal unit admissions for April, May and June 2023. The report indicated a slight increase in admissions to Neonatal Unit in part due to the lack of availability of Transitional Care and partly due to unavoidable

	respiratory problems. A respiratory ATAIN action plan is now part of the overall maternity quality improvement tracker and a business case to increase Transitional Care has been developed and submitted to CBIG. • Maternity Training plan MAG received a report outlining the local training plan for implementing of Version 2 of the Core Competency Framework. The plan has an increased training requirements broken down into 6 modules. The plan has been agreed with the Quadrumvirate, presented to the LMNS, and was submitted to LMNS strategic board in August 2023. • Community Connectivity MAG revived an options paper designed to resolve the community connectivity issues in the community setting. The maternity leadership continue to work with IT to resolve the difficulties. MAG has requested a breakdown of connectivity by location. • Birth Forecast and Capacity Mag received a forecast on the potential impact of increased antenatal booking on births, and subsequent pressure on the service. An analysis to include national length of stay for elective sections compared to MKUH and of births by month over the past three years is underway. Discussions are underway to increase elective theatre capacity and to flex the inpatient footprint on Ward 10.

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

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

Report History	Maternity Assurance Group July 2023
Next Steps	N/A
Appendices/Attachments	N/A

Meeting Title	**Trust Board**	**Date: September 2023**
Report Title	Maternity Clinical Workforce Paper	Agenda Item: 9.2
Lead Director	Name: Yvonne Christley	Title: Chief Nurse
Report Author	Name: Emma Mitchener	Title: Deputy Head of Midwifery

<table>
<tr><td>Key Highlights/ Summary</td><td colspan="4">This paper provides the Trust board with an overview of maternity staffing over the past six months.

<u>Obstetrics</u>
• Full compliance with the roles and responsibilities of the Royal College of Obstetricians and Gynaecologists of the consultant workforce document.
• 100% compliance with consultant attendance in listed clinical situations.
• The development and implementation of a Standard Operating Procedure to mitigating risk associated with noy having a separate obstetrics and gynaecology rota.

<u>Anaesthetics</u>
• Compliance with Anaesthesia Clinical Services Accreditation standard 1.7.2.1

<u>Neonatal</u>
• Full compliance with the British Association of Perinatal Medicine national standards for medical staffing and action plan to meet year NHSR year 5 BPAM criteria for Tier 3 doctors.
• Compliance with the service specification for neonatal nursing standards and progress towards increasing the number of registered nurses qualified in speciality.

<u>Midwifery</u>
• A breakdown of Birth Rate Plus to demonstrate how the required establishment has been calculated.
• Details of planned vs actual midwifery staffing, including evidence of mitigation/escalation for managing staffing shortfall.
• Summary of planned actions to address an increase in staffing establishment from the tabletop exercise or Birth Rate Plus report and timeline for the business case.
• The midwife to birth ratio in line with Birth Rate plus at 1:24.
• The % specialist midwives employed and those in management positions and actions to ensure the Trust meet the recommended 8-10%.
• Evidence demonstrating 100% compliance with supernumerary labour ward co-ordinator status and 1:1 care.

The biannual maternity staffing report below also ensures that the Trust is compliant with Safety Actions 4 and 5 of the NHS Resolutions Maternity Incentive Scheme. The paper also contains the minimum evident ail standards required.</td></tr>
<tr><td>Recommendation
(Tick the relevant box(es))</td><td>For Information ☐</td><td>For Approval √</td><td>For Noting ☐</td><td>For Review √</td></tr>
</table>

Strategic Objectives Links	Patient Safety, Compliance with National Safety Requirements
Board Assurance Framework (BAF)/ Risk Register Links	Midwifery staffing is currently on the risk register at a score of 15. No separate Obstetrics and Gynaecology rota is currently on the risk register at a score of 12. Obstetric middle grade rota gaps are currently on the risk register at a score of 6 - currently under review.

Report History	6 monthly maternity clinical workforce staffing paper
Next Steps	**To be reviewed at Trust Board.**
Appendices/Attachments	**Appendix 1 – SOP - Escalation process for urgent Obstetric consultant review if hot week consultant unavailable (13.00-18.00; Mon-Fri).** **Appendix 2 - Neonatal workforce staffing calculation tool**

Biannual Maternity Staffing Report - September 2023

Introduction

Adequate levels of maternity staffing are crucial to meet the needs of women, babies, and families and ensure a safe maternity service. This paper provides the Trust board with an overview of maternity staffing over the past six months (February to July 2023). The report's contents also ensure that the required standards for meeting compliance with the NHS Resolution Maternity Incentive Scheme evidential standards for Safety Actions 4 and 5 are met by [producing a biannual maternity staffing report.

Obstetric Workforce

The RCOG consultant roles and responsibilities principles have been incorporated into local clinical guidance. Consultant attendance is monitored and reported monthly on the divisional governance report and is summarised in the table below:

January 2023	*100%
February 2023	100%
March 2023	100%
April 2023	100%
May 2023	100%
June 2023	100%
July 2023	100%

*one case was reviewed and no breach was found

The final Ockenden report included an immediate and essential safety action: if a trust does not have a separate obstetrics and gynaecology rota, a risk assessment and escalation protocol must be in place and agreed upon at the Trust board. A risk assessment was completed and added to the risk register at a score of 12. A Standard Operating Procedure (SOP) was developed to mitigate any risk and approved in February 2023, detailing the escalation process should the Labour Ward hot week Consultant be unavailable if managing a gynaecology case. The approved SOP is available to view in Appendix 1.

As of August 2023, the middle-grade doctor rota has moved to 1 in 8 after recruiting two additional SAS doctors. One doctor commenced in post in February 2023, with an additional member expected to start in October 2023.However, the service has seen the resignation of 2 SAS Doctors, there has been successful recruitment with one post offered in June 2023, 1 additional post offered pending salary offer and lastly 1 was advertised with a plan for interview in September 2023.

There is some unavailability amongst the trainee Doctors, 1 member of the team commencing maternity leave and another who has had some time out of the programme who continues to shadow colleagues until September 2023.

It is anticipated that by October 2023 there will be 3 middle grade gaps. Obstetric medical staffing is currently on the risk register at a score of 6, however, given the middle grade doctor gaps,

there shall be additional discussions on the agreement the score moving forward until the gaps are recruited to and commenced in post.

The electronic recording of multidisciplinary attendance at ward rounds continues, multidisciplinary attendance at the twice daily safety huddles is not consistently achieved due to clinical prioritisation, the timings of the huddles are continually reviewed to identify any opportunities to maximise attendance; whilst enabling effective cascade of information to the site team.

There remains ongoing work around positive safety culture taking place within the department and, it has been recognised that there is not as much opportunity for the obstetric consultants to be as involved in the operational, service and strategic planning within maternity services as would be preferable. On review of the availability to support the governance functions within maternity services, the majority of SPA time is organised for a Wednesday, and, whilst most of the forums take place on a Wednesday, this also poses a challenge to attending forums on alternative days. There shall be an opportunity to review this once the medical workforce has reached and maintained their establishment, ensuring that the team's overall wellbeing is monitored and supported as required.

BLMK Local Maternity and Neonatal System (LMNS) have agreed funding for 1 PA to support obstetric involvement in LMNS functions, to enable consistent multidisciplinary input into key aspects of the maternity system. In addition, there is obstetric engagement and attendance to the maternal and neonatal safety collaborative across the Thames Valley network.

The results of the maternity culture survey were presented in June 2023 across the department to review and understand areas for focus to support the continued development of a positive safety culture in addition to continually assessing the baseline for service readiness for quality improvement. Alongside neonatal and operational colleagues, the quadrumvirate are enrolled on Co-Hort 2 of the Perinatal Culture and Leadership programme beginning in May 2023, this is due to be completed by October 2023.

Anaesthetic Workforce

The anaesthetic rota is compliant with ACSA standard 1.7.2.1, there is a duty anaesthetist available specifically for obstetrics 24 hours a day, with a written guideline for escalation to a consultant. The rota is available to view in order to provide evidence of the compliance of this standard. The RCOA GPAS (Guidelines for the Provision of Anaesthesia Services) 2022 states that there should be a duty anaesthetist and a consultant, or an autonomously practicing anaesthetist, during normal working hours, plus consultant cover for separate elective caesarean lists and clinics. We do not have a duty anaesthetist for labour ward during normal working hours, only a consultant or an autonomously practicing anaesthetist. A business case for another anaesthetist during the day was submitted and approved, however, funding for this is not available at present.

Neonatal Nursing Workforce

The staffing calculation tool to demonstrate compliance of the neonatal nursing workforce is included in Appendix 4. The neonatal nursing team is led by 1.96 WTE Band 7 Neonatal Unit Managers, who provide operational and clinical guidance. Additionally, a 1.0 WTE neonatal practice education facilitator supports education and development across the neonatal service. Recruitment and retention rates are positive within the neonatal unit, with 0.59 WTE Band 6 and 6.3 WTE Band 5 vacancies. All of these positions are currently in the final stages of recruitment. The unit has fully recruited nursery nurses.

The Neonatal Unit has supported the paediatric service during winter pressures, which has impacted the temporary staffing fill rate. A review of the induction for new starters has commenced to reduce the impact of redeployment within the initial six months of nurses joining the unit. Additionally, a workstream reviewing paediatric staffing and the service demand will develop opportunities for planned rotation within the paediatric and neonatal settings.

The neonatal service is working towards increasing the number of nurses qualified in speciality to 70.5%. Currently, 56% of neonatal nurses are qualified in speciality. COVID has adversely impacted the Trust's trajectory for increasing the number of nurses qualified, and an action plan has been developed and is in place. One nurse is expected to complete her training in September, and an additional four nurses will commence their training in September. To meet the 70.5% requirement, the Trust is required to train 2.44 WTE.

To support ongoing development to advanced practice posts within the service, an Advanced Neonatal Nurse Practitioner has been recruited, and an additional training post is being reviewed. Ockenden funding received in 2022 has also supported allied health professional input into the neonatal service, enabling the development of enhanced pathways and opportunities to embed these roles within the neonatal environment. In June 2023, NHS England provided funding for quality roles, which has been utilised to support a 0.5WTE Band 7 Risk and Governance Lead Nurse and 0.2WTE Band 7 Family Integrated Care (FIC) Lead Nurse.

Neonatal Medical Workforce

The neonatal medical workforce meets the BPAM requirements for Tier One and Tier Two doctors and was compliant with the requirement for NHSR in year 4.

The workforce currently does not meet the requirement for NHSR year 5 as the BPAM criteria for Tier 3 doctors is not met. This requirement stipulates that any consultant covering neonates must work a minimum of 4 attending weeks (COTW) per year. The frequency of general paediatric consultants undertaking neonatal duties is below this expectation and currently, 10 consultants do not meet this requirement.

An action plan is currently in place to achieve compliance with Tier 3 medical staffing, a business case has been approved to increase from 13 to 14 consultants which will contribute to an increase in the number of attending weeks on the neonatal unit by the paediatricians from 2 to 4 weeks, with the aim of meeting the Tier 3 requirements. The recruitment process for the additional consultant post is underway.

BLMK Local Maternity and Neonatal System (LMNS) have allocated 0.5 PA to support neonatal medical input into the neonatal workstreams across the system, however, MKUH is unique in its organisation within the region as it sits within two separate systems for neonatal transformation and optimisation, including BLMK and Thames Valley. This results in a requirement for double reporting and maintenance of workstreams for improvement within different systems which at times, have alternative priorities. The requirement for engagement in the neonatal system is increased due to reporting mechanisms between alternative systems, negatively impacting on neonatal medical availability to support the progress of improvement.

The neonatal medical rota's have 2 WTE middle grade vacancies, the recruitment process is underway with interviews taking place this month. Following successful recruitment to these posts, as of November there shall be 0.5WTE vacancy due to maternity leave. The current position creates challenges with ensuring effective medical cover across the paediatric and neonatal service.

Midwifery Workforce

Recruitment and Retention

The funded midwifery establishment (Bands 5-6) is 138 WTE, and the current registered midwifery vacancy rate is 14.1% (19.4 WTE). The vacancy rate for midwifery support workers is 15.4% (4.5 WTE). The Trust is actively working to reduce these vacancies and expects to be fully recruited to the current establishment between September and December 2023 based on projections of incoming and outgoing staff.

To increase and maintain the maternity workforce, the Trust has implemented a recruitment and retention plan that a retention midwife supports. Additionally, the Trust participates in a regional approach to advertising midwifery roles, including alternative platforms to NHS jobs. Varied recruitment opportunities have been explored and implemented, including return-to-practice, international recruitment, bank-only contracts, and legacy midwives.

Retention activities are focused on staff experience with a direct focus on staff wellbeing, flexibility in working practices and development. A quality improvement plan is in place for workforce and culture, as the continued growth and maintenance of a positive workplace culture is a consistent focus.

It is crucial to prioritise the recruitment and retention of Band 6 midwives to strengthen the midwifery skill mix, provide support for newly qualified and student midwives, and create opportunities for career progression. To achieve this, the retention midwife is facilitating the ongoing growth and development of the Band 6 workforce, particularly as this group has been identified as a hard-to-recruit staff group.

The maternity service has completed the direct workforce support offer. In addition to the existing flexible working opportunities for staff, a survey has been conducted to identify other areas where flexible working can be prioritised within the workforce.

Links have been created with a new provider university, and an increase in student numbers will support an ongoing midwifery pipeline at various entry points within the year. The Trust is also looking into an apprentice route for existing support staff to enter midwifery training. An external review of clinical placements has been conducted, and recommendations have been made to expand student capacity. The Learning Education Lead (LEL) role remains in place to support students and has received positive feedback from learners.

A lead PMA (Professional Midwifery Advocate) has been appointed to support restorative clinical supervision and implement the A-EQUIP model. Additionally, five more midwives are in the process of completing their PMA training, which will improve the support available for the midwifery workforce. The ideal ratio of midwife to PMA is 1:20, but currently, the service has a ratio of 1:26. The PMA team conducts a weekly wellbeing walk across all clinical areas to connect with staff members on different shifts and evaluate the workplace environment.

The exit interview process remains successful, with the department offering an opportunity to attend a review meeting with a selected member of the team, qualitative information relating to the rationale for leaving is collected to support continued development within the department. Before the interview, the line manager will have a discussion with the employee to determine if there are any measures that can be taken to retain them.

The TRiM (Trauma Risk Management) team has organised support for midwifery and paediatric staff following traumatic events in the workplace. This practice is successfully embedded within the department.

Additionally, a review of the workforce took place to identify other professionals with the

opportunity to positively input into the provision of maternity care, enabling resilience of care delivery included the identification of an opportunity to implement registered nurses into the inpatient ward shift plan. A business case was developed and submitted to gain funding for the implementation of registered nurses into the shift plan on the maternity inpatient ward, which received an A rating following review at the business case review panel. The business case was subsequently not supported at Trust Executive Group due to a requirement for further data of the uptake of registered nurse regular temporary staffing shifts implemented on the maternity inpatient ward, including the impact of this on care provision.

Specific training has been identified to support the registered nurses with the development of skills pertinent to maternity and a pipeline for development is in place with the availability of the Midwifery master's course for registered nurses. This year there is one candidate enrolled on the midwifery master's course with further expressions of interest to be released for next year.

In terms of Maternity Support Worker (MSW) a mapping exercise has been undertaken and the skills and competencies of all maternity support workers have been mapped, and a development pathway organised to detail the opportunities for career progression. A training provider with a maternity specific support worker apprenticeship has been selected and the initial co-hort of staff are being enrolled. The regionally agreed job descriptions have been progressed through the trust processes for approval and implementation for all newly appointed staff. The consultation completed in June 2023 with those staff members mapped across that were able to be with additional members of the team proceeding through the upskilling process and commencing the apprenticeship programme in staggered cohorts.

This will subsequently re-organise the workforce due to the adjustments in the roles and responsibilities of the Band 2 to 3 posts, with the increase in Band 3 roles and decrease in band 2 roles, supporting increased efficiency in midwifery allocation to midwifery specific tasks.

Midwife to Birth Ratio

The Trust has a systematic process for setting midwifery staffing establishments. This process utilises Birth-rate Plus© as the nationally recognised tool for assessing the needs of women for midwifery care throughout pregnancy, labour and the postnatal period in hospital and community settings. Birth-rate Plus© is the only approved demand and capacity modelling tool for assessing and organising midwifery staffing (this is currently under review following the final Ockenden report, which included an immediate and essential safety action to determine the model's suitability).

A Birth Rate Plus Workforce assessment was completed in 2021, and the report was released in 2022. The recommended midwife to birth ratio in the Birth Rate Plus workforce report in 2021 is 1:24 resulting from the of the increased complexity in care of those accessing maternity care at MKUH. Birth Rate Plus 2021 recommends a clinical funded establishment of 160 WTE including Band 3 MSW's. As previously discussed at Trust Board once the division are fully recruited to the current staffing establishment work will commence on a business case to support an additional 6 WTE midwives.

	Current funded establishment (post-Final Ockenden)	Proposed establishment (post-BR+ 2022)
RM (clinical), Band 6 WTE	138	144

The midwife to birth ratio is published on the monthly obstetric dashboard for the previous year

has fluctuated between 1:28 – 1:36.

Month	Ratio
July 2022	1:34
August 2022	1:31
September 2022	1:36
October 2022	1:35
November 2022	1:30
December 2022	1:31
January 2023	1:33
February 2023	1:30
March 2023	1:29
April 2023	1:34
May 2023	1:31
June 2023	1:32
July 2023	1:28

The fluctuation has been impacted by staff unavailability, and birth rate.

Planned versus Actual Midwifery Staffing

The section below provides a summary of the planned versus actual monthly fill rates for midwifery staffing. The fill rate includes substantive and temporary staff fill, approximately 10% of the fill rate each month is temporary staff, this comprises of substantive staff on bank shifts.

Month	Fill Rate %
January 2023	93.1
February 2023	98.6
March 2023	97.3
April 2023	89.8
May 2023	89.6
June 2023	94
July 2023	96.6

The fill rates above are based on the entire service and calculated according to the precise shift requirements each month (which change depending on community midwifery requirements). The midwifery staffing across all inpatient and outpatient areas is dynamically adjusted to meet the needs of the service. It is therefore necessary to review the midwifery staffing fill rate across the service instead of area specific.

Midwifery staffing is reviewed daily to identify the required staffing within all areas to manage the planned and acute activity. Staffing is reported to the site team at 08.30 and 18.30 flow meetings. Maternity Safety Huddles occur twice daily at 10:00 and 15:30, where a SIT REP is completed to detail the daily staffing and activity. These reports are sent to the site team following the completion of the huddles.

A maternity escalation procedure is in place detailing planned actions to take in the event of staffing, activity, or capacity concerns. A midwifery business contingency plan is also in place to support the management of midwifery staffing shortfalls that actions within the escalation procedure cannot mitigate.

In addition, a maternity manager is on call 24 hours a day, 365 days a year, to support the continued provision of safe maternity services. The maternity bleep holder role supports the weekday operational management of the maternity service, specifically to enable the effective organisation of planned activity against the acute service provision. The regional maternity OPEL rating is also used to support the identification of operational challenges with maternity services and is reported at all site team contacts and as part of the internal reporting mechanisms.

The Birth Rate Plus acuity app was implemented on labour ward in April 2022 to support midwifery staffing data collection and decision-making regarding allocation of staff. The escalation procedure was updated to reflect the new categorisation of complexity in care provision, demonstrating the WTE demand required to deliver the elements of care based on acuity. As of June 2023, the Birth rate organised a system wide Birth Rate Plus data sharing function to support management of maternity capacity within the BLMK LNMS system.

Birth rate plus produces reports detailing the staffing factors impacting on the provision of care, which is reported monthly through the governance report. A monthly maternity staffing update is reported through a divisional governance report containing the planned versus actual midwifery fill rate.

Birthrate Plus Acuity Tool (Delivery Suite)

The Birthrate Plus Acuity Tool supports the real-time assessment of workload in the Delivery Suite arising from the number of women needing care and their condition on admission and during labour and birth. Where acuity on the delivery suite demands specialist midwives are deployed to support the delivery suite rota, and agency and bank midwifery shifts are managed with authorisation by the Divisional Chief Midwife and Deputy Head of Midwifery. The Divisional Chief Midwife, Deputy Head of Midwifery and Matrons are all required to support at times of escalation and are available 24/7 via an on call rota when the service is in escalation.

The accuracy of the RAG status above is dependent on four hourly assessments that demonstrate the numbers of midwives needed to meet the needs of women, based on the minimum standard of 1:1 care for all patients in labour and increased ratios of midwifery time for

women in the higher need categories.

The Birth Rate Plus team has provided training to staff in the delivery suite. The aim of which is to ensure that submissions are consistent and timely. To accurately reflect acuity on the delivery suite a confidence factor of over 85% should be achieved. The confidence factor achieved is summarised in the table below:

Month	Confidence Factor %
January 2023	79.03
February 2023	80.95
March 2023	78.49
April 2023	82.78
May 2023	76.9
June 2023	82.2
July 2023	82.26

A review of the barriers to complete data submission was conducted, and an increased focus on trigger points to support compliance with data completion has been implemented.

One to One in Established Labour

The Trust aims to ensure that women in established labour receive 1:1 care and is reported on the obstetric dashboard with an expected parameter of 100%, excluding those Born before arrival (BBA) where this would not be possible to achieve. This has been consistently reported as 99.32% to 100%:

Month	% 1:1 Care
February 2023	99.67%
March 2023	99.66%
April 2023	100%
May 2023	100%
June 2023	99.68%
July 2023	99.32%

Labour Ward Co-Ordinator Supernumerary Status

According to NHS Resolutions, the labour ward coordinator must have supernumerary status to maintain situational awareness, proper oversight, and leadership. This means the coordinator should not provide 1:1 care for a woman in established labour or maintain a caseload. Instead, their role is to provide oversight of the labour ward and offer support and assistance to other midwives. This includes providing fresh eyes on CTG readings, giving second opinions and reviews, assisting midwives during birth, and providing support etc. It is important to note that performing any of these duties does not constitute a loss of supernumerary status.

The supernumerary status of the labour ward co-ordinator is summarised in the table below. The Trust met the CNST year 5 standard for supernumerary status for all months except February 2023. There was a single exceptional circumstance in February when the Labour Ward co-ordinator was not supernumerary for 50 minutes. All other occurrences impacting the labour ward coordinator's supernumerary status were one-time events and did not happen more than once a week.

Month	Supernumerary Status % *
February 2023	CNST Definition - 98% Self-Reported – 98% (CNST non-compliant – providing 1:1 care in labour for 50 minutes whilst awaiting arrival of the on-call RM, lead on call aware and escalated in)
March 2023	CNST Definition - 100% Self-Reported – 99% (CNST compliant – not regular (more than once a week) not providing 1:1 care in labour)
April 2023	CNST Definition - 100% Self-Reported – 97.3% (CNST compliant – not regular (more than once a week) not providing 1:1 care in labour)
May 2023	CNST Definition - 100% Self-Reported – 98.4% (CNST compliant – not regular (more than once a week) not providing 1:1 care in labour)
June 2023	CNST Definition - 100% Self-Reported: 94.4% CNST compliant – not regular (more than once a week) not providing 1:1 care in labour)
July 2023	CNST Definition - 100% Self-Reported: 96.26% CNST compliant – not regular (more than once a week) not providing 1:1 care in labour)

*The CNST definition of supernumerary status has further been updated with the release of CNST year 5 – due to previous feedback from the labour ward co-ordinators in relation to the appropriateness of the definition the reporting has continued to incorporate CNST compliance and self-reporting. CNST released a further update detailing that self-reported supernumerary status would be valued.

Labour ward coordinator supernumerary status is reviewed and reported monthly, through the divisional governance report, and it is identified from the submission of red flags on the Birth Rate Plus acuity app.

Red Flags

A staffing red flag event is a warning sign to alert that midwifery staffing is not meeting the acuity and activity at that time. If a staffing red flag event occurs, the registered midwife in charge of the service should be notified and necessary action taken to resolve the situation. Between February and July 2023 there were 147 Red Flags raised.

Number & % of Red Flags Recorded

From [illegible] to [illegible]

Code	Red flag	Number	%
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	

Number & % of Red Flags Recorded

From [illegible] to [illegible]

Code	Red flag	Number	%
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
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[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	

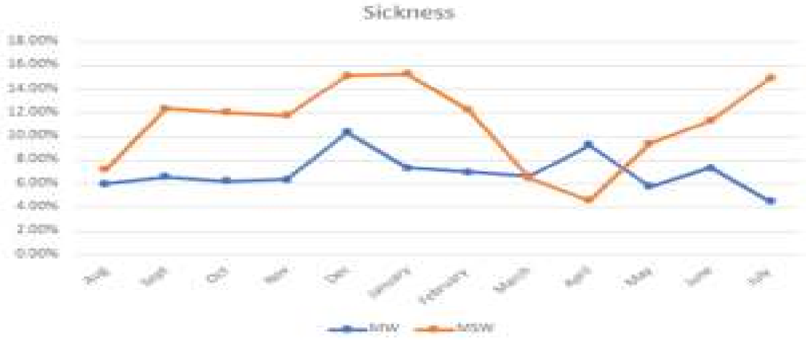
The tables above show the most common reg flag related to delays or cancellations of time-critical activities. This red flag is predominantly associated with delays in the progress of those who have commenced on induction of labour pathway. The second most frequently raised red flag was for the non-supernumerary status of the labour ward coordinator (not the CNST definition). The third highest reported red flag was for the delay between admission and commencement of the induction of labour process.

Improving the induction of labour pathway is a current focus to enhance the care and experience of service users. Consultant Midwives are conducting audits to identify the necessary improvements. The Maternity Voices Partnership is also collaborating with the Trust and the multidisciplinary team to improve the delivery of the pathway.

Unavailability

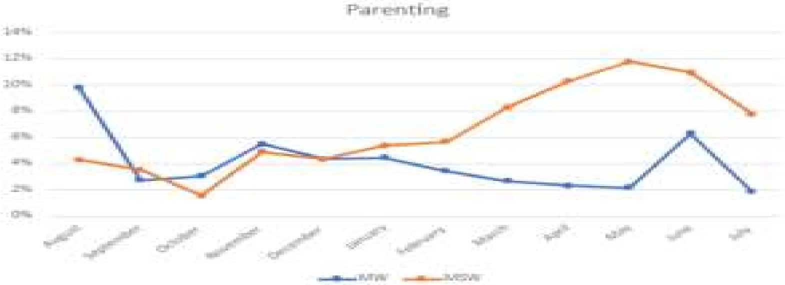
The current headroom applied to clinical midwifery posts is 22%, this includes 4% non-recruitable sickness absence. Amongst Registered Midwives, sickness absence has slowly decreased from slightly above 6% in February to just above 4% in July 2023. Midwifery sickness absence is reviewed across the service as opposed to individual areas due to the fluidity of movement of staff daily to support the overall maternity service provision.

Despite a reduction in sickness absence in March and April, Midwifery support workers have had an increase in sickness absence, as illustrated in the graph below.



Return to work interviews and sickness absence meetings continue to support managing sickness effectively. Themes are being identified to support this group of staff. It should be noted that midwifery support workers are a very small cohort of staff and while the sickness absence rate is high it equates to the absence of 1 maternity support worker per shift.

Parenting leave has remained below 4% for Registered Midwives most of the reporting period except for June which saw parenting leave increase to above 6%. For midwifery support workers parenting leave has steadily increased for the reporting period from just under 6% in February to 12 % in May.

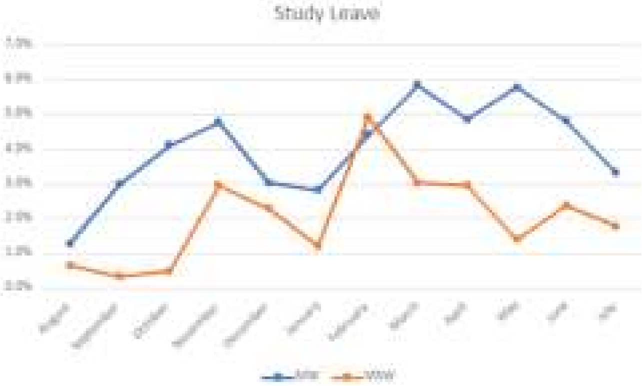


Parental leave cover is organised on a secondment basis, fixed term position or bank, depending on the role.

Due to the requirements for mandatory midwifery training, a 5% to 6% uplift in headroom is required to support the delivery of training as mapped against the core competency document. Unavailability due to study leave increased in February to comply with the training requirements for implementing physiological CTG and the Human Factors training. Mandatory training is also organised annually to reduce the impact on staffing within more challenging periods, including training being mapped across ten months, avoiding July and August because of high rates of annual leave.

The organisation of external training has also impacted fluctuations in study leave. This has included: baby lifeline emergencies in the community; birth rights informed consent; maternity specific cultural competency; baby lifeline physiological CTG; human factors train the trainer; APEC pre-eclampsia management; specialist bereavement; CPAL – coaching and peer assisted learning; domestic abuse, stalking and honour based; perinatal and infant mental health; causal analysis; cognitive interview technique; PSIRF modules; PEARLS – perineal repair; NLS (Newborn Life Support); NIPE (Newborn and Infant Physical Examination); PMA (Professional Midwifery Advocate); PGCERT – teaching qualification.

Core competency training for registered midwives is maintained at above 90%. This has been achieved by enabling midwives to complete specific training as bank to reduce the impact on the substantive rota.



The annual leave allocation for February and March was above the 17% headroom for Registered Midwives and has remained marginally below headroom for the rest of the reporting period. Midwifery support workers annual leave allocation has been below the 17% in April, May, and June. The peaks in annual leave are associated with the year-end annual leave allowance and school holidays. In a predominantly female workforce this trajectory is expected and mitigated by bank utilisation during holiday periods, when flexibility is an increased factor in availability. Matrons and Managers are working with staff to ensure annual leave allocation is taken evenly throughout the year.

The Divisional Chief Midwife is working with the corporate nursing team to replicating the e rostering assurance check and confirm meetings for all maternity areas. Roster check and confirm takes place to review the impact of pre-determined unavailability and roster requirements are in place to ensure appropriate management of headroom across the year.

Specialist Midwives and Midwifery Management Roles

As part of the midwifery staffing model, Birth Rate Plus sets the expected percentage of specialist midwives and non-clinical midwifery managers to enable the delivery of core functions within maternity services. This parameter is expected to be between 8% and 10%, with a mitigation plan if the specialist and managerial input falls below 8%.

Based on the previous Birth Rate Plus report, specialist midwife roles at MKUH equate to 10%, which is within the expected parameters. The Trust also has several externally funded specialist roles to comply with national and regional workstream deliverables. The revised Birth Rate Plus report recommends a non-clinical specialist and role allocation of 10% which equates to 16 WTE. Following the report, specialist roles have been implemented and the Trust has achieved compliance with this requirement.

Each of the specialist midwives also has a percentage of their role which is clinically based, and the specialist midwives support the daily on call escalation in line with the maternity escalation procedure. The midwifery senior leadership team all take part in the 24-hour on call maternity manager rota, which is in place to supports the continual management of capacity and activity across the maternity service.

Continuity of Carer (CoC)

The Trust were operating 6 CoC teams until indicators identified a requirement for a further review of the community and CoC services, following which the impact of unavailability within the service overall, coupled with staff feedback led to a recommendation to pause the continuity of carer (CoC) teams until the staffing establishment and vacancies within the service had been addressed. CoC still forms part of the national maternity transformation programme however the national and local challenges involved in implementing and sustaining this model are still to be addressed and the Trust awaits guidance in view of the current pause in rollout following the Immediate and Essential Actions of the final Ockenden Report.

Conclusion

Maternity staffing is complex and can change rapidly based on individual care needs and the complexities of cases. The maternity service has clear and explicit escalation policies and procedures to ensure oversight of maternity staffing and maintain care and safety requirements. The report demonstrates an improved vacancy trajectory, particularly among registered midwives and is expected to be fully recruited to the current establishment established by December 2023. A clear recruitment and retention plan is in place that utilises a diverse skill mix, enhancing care provision and strengthening the clinical workforce.

Appendix 1 – SOP - Escalation process for urgent Obstetric consultant review if hot week consultant unavailable (13.00-18.00; Mon-Fri).

Appendix 2 - Neonatal workforce staffing calculation tool

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Standard Operating Procedure (SOP) Number: MIDW/SOP/050

SOP Title: Escalation process for urgent Obstetric consultant review if hot week consultant unavailable (13.00-18.00; Mon-Fri).

Classification :	Standard Operating Procedure
Authors Name:	Nandini Gupta (Clinical Director), Sanyal Patel (Emergency gynae lead), Joyce Elliot (Rota lead)
Authors Job Title:	Consultants Gynaecology
Authors Division:	Women & Children's Division
Departments/Group this Document applies to:	Obstetrics & Gynaecology Medical Staff

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SOP Statement

The purpose of this standard operating procedure (SOP) is to provide guidance for escalation between 1300 - 18.00 hours (Mon -Fri) if the Labour Ward hot week Consultant is in theatre with an emergency gynaecology case and is not available for urgent / time critical Obstetric Consultant input.

Executive Summary

If the Labour Ward hot week Consultant is scrubbed in theatre with an emergency gynaecology case and an urgent Consultant review is needed, the labour ward Consultant will directly contact or instruct for a specific Consultant colleague to be contacted to assist with critical obstetric need.

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1.0 Roles and Responsibilities:

The hotweek or oncall Consultant must be available quickly in person and therefore should not be engaged in other activities that could delay attendance. Duties such as elective surgery, clinics or off-site work should not be undertaken whilst oncall. (1).

Hot Week Consultants:
Labour Ward Hot week Consultant (covering Labour Ward, ADAU, Ward 9 & 10) Monday – Friday 08:00 – 18:00. From 13:00 – 18:00, the hot week Consultant will also be responsible for reviewing and managing new gynaecological admissions and any acutely unwell gynaecology patients.

Emergency Gynaecology Consultant - covering emergency gynaecology admissions, Early Pregnancy Assessment Unit (EPAU), gynaecology inpatient ward round, as well as Surgical Management of Miscarriages (SMOMs) and emergency gynaecology operating. Monday -Friday 08:00-13:00.

Weekday on-call Consultant: Consultant covering all areas 17:30 – 08:00
Expected to be on site until 21.00

Emergency Gynaecology Registrar – (covering emergency gynaecology 8.00-20:30 weekdays and weekends).

Weekend Consultant On-Call: Consultant covering all areas
Saturday 08:00 – Monday 08:00. Onsite 8.00-13.00 and 19.30-21.00.

2.0 Implementation and dissemination of document

This document will be published on the Trust Intranet.

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3.0 Processes and procedures

3.1 Escalation process for urgent Obstetric consultant review if hot week consultant unavailable

Labour ward consultant to assess Labour Ward activity/acuity before going to theatre with an emergency gynaecology case and to alert the LW co-ordinator of how to contact in an emergency

↓

The labour ward consultant should also identify a Consultant colleague who will be contacted if urgent escalation is required, and they are unable to leave theatre.

↓

If the labour ward consultant is scrubbed with an emergency gynaecology the oncall registrar (either obstetrics or gynaecology) will review and manage appropriately.

↓

If physical presence of the Consultant is needed, the Consultant will handover the case to one of the oncall registrars and attend if safe to do so.

↓

If unable to attend in person, the labour ward Consultant will contact the most appropriate identified Consultant colleague directly and request them to attend the relevant / appropriate area.

The frequency of this occurrence will be prospectively audited and a radar will be completed by the hot week Consultant.

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4.0 Statement of evidence/references

References:

1. https://www.rcog.org.uk/media/iggfguvs/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
1	Jan 2023	Nandini Gupta, Sanyal Patel, Joyce Elliot	Created Document

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Leanne Andrews	Audit and Guideline Lead Midwife	18/01/23	18/01/23	Formatting changes	Yes

Neonatal Nursing Workforce Tool (2020): Milton Keynes

Input unit details		
Trust	Milton Keynes	
Unit	Milton Keynes	
Designation	LNU	
Completed by	Lisa Viola	
Date completed	10/08/23	
Activity period	2022/23	Days in period 365

Input activity (HRG 2016)	Activity	Declared cots
HRG 1 (IC)	280	1
HRG 2 (HD)	1,391	4
HRG 3 (SC)	2,707	12
Total	**4,378**	**17**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY	Budget	In post
Total QIS	23.86	15.86
Total Non QIS	10.22	11.92
Total Non Reg	6.07	5.79
Total	**40.15**	**33.57**

Activity (HRG 2016)

	Activity	*For calculations* 80% of daily activity	*For calculations* WTE (6.07 / BAPM)	Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
HRG 1	280	*1.0*	*6.07*	1	76.71%	1	0
HRG 2	1,391	*4.8*	*3.04*	4	95.27%	5	-1
HRG 3	2,707	*9.3*	*1.52*	12	61.80%	9	3
Total	**4,378**			**17**	**70.56%**	**15**	**2**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY

NB total nurse staffing required to staff declared cots = 42.49, of which 29.74 (70%) should be QIS

	Current position: Budget	Current position: In post	Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
Total nursing staff	40.15	33.57	40.42	-0.27	-6.85
Total reg nurses	34.08	27.78	36.20	-2.12	-8.42
Total QIS	23.86	15.86	26.35	-2.49	-10.49
Total non-QIS	10.22	11.92	9.85	0.38	2.07
Total non-reg	6.07	5.79	4.22	1.85	1.57
Reg nurses as % nursing staff	84.9%	82.8%	89.6%		
QIS as % reg nurses	70.0%	57.1%	72.8%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependancy care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

Meeting Title	Trust Board of Directors	Date: 07 September 2023
Report Title	2023-24 Executive Summary M04	**Agenda Item Number: 10**
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 8,385 ED attendances in July 2023, a decrease of 372 attendances when compared to June 2023. - The percentage of attendances admitted, transferred or discharged within 4 hours was 75.3%, an improvement of 0.9% when compared to June 2023. - 78.1% of ambulance handovers took less than 30 minutes in July 2023 and 96% took less than 60 minutes. **Outpatient Transformation:** - There were 33,535 outpatient attendances in July 2023, a decrease of 3789 attendances compared to June 2023. - 12.29% of these appointments were attended virtually and 5.9% of patients did not attend their appointment in July 2023. **Elective Recovery:** - There were 2,259 elective spells in July 2023, an increase of 120 spells from June 2023. - At the end of July 2023, 39,303 patients were on an open RTT pathway: o 3,226 patients were waiting over 52 weeks: 418 more than in June 2023. o 668 patients were waiting more than 65 weeks. - At the end of July 2023, 10,770 patients were waiting for a diagnostic test, of which 72.4% were waiting less than 6 weeks. **Inpatients:** - Overnight bed occupancy in adult G&A beds was 88.3% during July 2023, within the threshold of 92% and an increase in performance in comparison to June 2023 of 90.1%. - A considerable proportion of beds were unavailable due to: o 98 super stranded patients (length of stay 21 days or more). o 71 patients not meeting the criteria to reside. **Human Resources:** - In July 2023: o Substantive staff turnover decreased to 14.4% in July from 14.9% in June, and above the threshold of 12.5%. o Agency expenditure decreased to 3.1% from 4.1% in June 2023, below the threshold of 5% and the lowest so far this year to date. o Appraisals (excluding doctors) remained the same at 93% from June 2023, above the 90% threshold. o Mandatory Training increased to 96% in July from 95% in June, and above the 90% threshold.

	Patient Safety: - In July 2023, the following infections were reported: ○ E-Coli: 4 ○ C. Difficile: 1 ○ P. aeruginosa bacteraemia: 1 ○ Klebsiella Spp bacteraemia: 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	*Finance and Investment Committee, September 2023*
Next Steps	*Trust Executive Committee, September 2023*
Appendices/ Attachments	ED Performance – Peer Group Comparison

Trust Performance Summary: M04 (July 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	43.2%	92%
4.5a	RTT Patients waiting over 65 weeks	465	0
4.6	Diagnostic Waits <6 weeks	85.1%	99%

To ensure that the continued 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

July 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 13 months data
4.1a	ED 4 hour target (includes UCS)	76%	76%	74.8%	75.3%	x	▲	x	
4.2	RTT Incomplete Pathways <18 weeks	[illegible]	43.2%		[illegible]	x	▼		
4.5b	RTT Patients waiting over 65 weeks	0	465		668	x	▼		
4.6	Diagnostic Waits <6 weeks	[illegible]	85.1%		[illegible]	x	▼		
[illegible]	62 day standard (Quarterly)	85%	85%		[illegible]	x	▼		

The percentage of ED attendances that were admitted, transferred, or discharged within 4 hours was 75.3%, a 0.9% improvement on June 2023 performance. This exceeded both the national performance of 74% and the performance of most other trusts within our Peer Group (see Appendix 1).

The volume of open RTT pathways was 39,303, decreasing from 39,360 at the end of June 2023. Of this total, 668 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.

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

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

In Q1 2023/24, our 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 48.7% against a national target of 85%, declining from 54.6% in the previous quarter. The percentage of patients to begin cancer treatment within 31 days of a decision to treat improved to 94.2% but remained 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 76.1% against the national target of 93%. Our 28 Day Faster Diagnosis was 70.2% declining from 76.73% in the previous quarter.

3.0 Urgent and Emergency Care

During July 2023, 4 out of the 5 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%	0.75%	1.13%	✗	▼	✓	
3.2	Ward Discharges by Midday	25%	25%	14.1%	15.5%	✗	▲	✗	
3.5	Patients not meeting Criteria to Reside	50			71	✗	▲		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)	50			98	✗	▲		
3.9a	Ambulance Handovers <30 mins (%)	95%	95%	79.7%	78.1%	✗	▲	✗	

Cancelled Operations on the Day

In July 2023, there were 27 operations that were cancelled on the day for non-clinical reasons, representing 1.13% of all planned operations. Most of the cancellation reasons given were related to insufficient time, unavailability of theatre staff and unavailability of anaesthetist.

Patients not Meeting Criteria to Reside

The number of inpatients not meeting the criteria to reside at the end of July 2023 was 71. This was notably fewer than June 2023, which saw 102 inpatients not meeting the criteria to reside against the a 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 98, an improvement in performance compared to 122 patients reported at the end of June 2023.

Ambulance Handovers

In July 2023, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 78.1%; an increase in performance compared to 74.7% in June 2023.

4.0 Elective Pathways

During July 2023, 2 out of 4 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 13 months data
3.1	Overnight Bed Occupancy - Adult G&A	92%	92%	[illegible]	88.3%	✓	▲	✓	
4.2	RTT Incomplete Pathways <18 weeks	[illegible]	[illegible]		[illegible]	✗	▼		
4.4	RTT Total Open Pathways	[illegible]	[illegible]		[illegible]	✓	▲		
4.6	Diagnostic Waits <6 weeks	[illegible]	[illegible]		[illegible]	✗	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 88.3% in July 2023, within the desired 92% threshold.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of July 2023 was 40.6% and the number of patients waiting over 65 weeks was 668. Total RTT open pathways was 39,303.

Diagnostic Waits <6 weeks

At the end of July 2023, performance was 72.38%, declining from 75.2% in June 2023. This was the lowest diagnostic performance that has been reported since June 2022 (71.5%).

5.0 Patient Safety

Infection Control

In July 2023, the following infections were reported:

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

ENDS

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

Chief Executive: Joe Harrison
Chair: Alison Davis

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:

May 2023 to July 2023 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	May-23	Jun-23	Jul-23
Homerton Healthcare NHS Foundation Trust	77.4%	76.7%	78.0%
Milton Keynes University Hospital NHS Foundation Trust	73.5%	74.4%	75.3%
Buckinghamshire Healthcare NHS Trust	68.5%	66.5%	72.8%
The Hillingdon Hospitals NHS Foundation Trust	71.9%	73.1%	72.6%
Mersey and West Lancashire Teaching Hospital (Formerly Southport and Ormskirk)	75.5%	77.4%	71.0%
North Middlesex University Hospital NHS Trust	71.3%	68.7%	70.1%
Oxford University Hospitals NHS Foundation Trust	70.3%	66.9%	68.5%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	64.4%	65.4%	67.8%
Barnsley Hospital NHS Foundation Trust	78.7%	69.2%	67.3%
Northampton General Hospital NHS Trust	67.7%	67.1%	66.1%
Mid Cheshire Hospitals NHS Foundation Trust	65.9%	67.4%	64.8%
The Princess Alexandra Hospital NHS Trust	53.0%	53.7%	55.5%

Board Performance Report 2023/24
July 2023 (M04)

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) ★		0.0	0.0		106.0	✗	▲		
1.2	Mortality - (SHMI)		100.0	100.0		106.6	✗	▼		
1.3	Never Events		0	0	0	0	✓	▬	✓	
1.4	Clostridium Difficile		13	<6	13	1	✓	▲	✗	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▬	✓	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.08	0.07	✓	▲	✓	
1.7b	Midwife to birth ratio (Actual for Month)		28			Not Available				
1.8	Incident Rate (per 1,000 bed days)		50	50	53.42	61.01	✓	▲	✓	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		27	12	7	4	✗	▼	✓	
1.11	MSSA		17	<8	3	0	✓	▲	✓	
1.12	VTE Assessment		95%	95%	97.7%	97.6%	✓	▼	✓	
1.14	Klebsiella Spp bacteraemia		14	<6	2	1	✓	▼	✓	
1.15	P.aeruginosa bacteraemia		9	4	2	1	✗	▬	✓	

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%	83.2%	70.7%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1%	1%	0.73%	1.13%	✗	▼	✓	
2.5	Over 75s Ward Moves at Night		1,500	625	524	124	✓	▲	✓	

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%	90.2%	88.3%	✓	▲	✓	
3.2	Ward Discharges by Midday		25%	25%	14.1%	15.5%	✗	▲	✗	
3.3	Weekend Discharges		63%	63%	60.0%	63.2%	✓	▲	✗	
3.5	Patients not meeting Criteria to Reside		50			71	✗	▲		
3.6a	Number of Stranded Patients (LOS>=7 Days)		184			243	✗	▲		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)		50			98	✗	▲		
3.8	Discharges from PDU (%)		12.5%	12.5%	8.0%	8.9%	✗	▲	✗	
3.9a	Ambulance Handovers <30 mins (%)		95%	95%	79.7%	78.1%	✗	▲	✗	
3.9b	Ambulance Handovers <60 mins (%)		100%	100%	96.8%	96.0%	✗	▲	✗	

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%	74.6%	75.3%	✗	▲	✗	
4.1b	Total time in ED no more than 12 hours		95%	95%	93.5%	93.2%	✗	▼	✗	
4.1c	Triage within 15 Minutes		90%	90%	61.5%	66.0%	✗	▲	✗	
4.2	RTT Incomplete Pathways <18 weeks		47.4%	44.0%		40.6%	✗	▼		
4.4	RTT Total Open Pathways		39,636	41,524		39,303	✓	▲		
4.5a	RTT Patients waiting over 52 weeks		1,920	2,293		3,226	✗	▼		
4.5b	RTT Patients waiting over 65 weeks		0	404		668	✗	▼		
4.6	Diagnostic Waits <6 weeks		85.6%	85.2%		72.4%	✗	▼		
4.7	All 2 week wait all cancers (Quarterly) ✎		93%	93%		76.1%	✗	▲		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96%	96%		94.2%	✗	▲		
4.9	62 day standard (Quarterly) ✎		85%	85%		48.7%	✗	▼		
4.9b	28 Day Faster Diagnosis (Quarterly) ✎		75%	75%		70.2%	✗	▼		

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		65,366	14,602	Not Available	▼	Not Available	
5.1b	Total ASIs		0	0		2,490	✗	▼		
5.1c	Total RTT Non-Admitted Open Pathways		32,776	34,603		33,386	✓	▲		
5.1d	Total RTT Admitted Open Pathways		6,860	6,921		5,917	✓	▼		
5.2	A&E Attendances		103,507	42,951	33,547	8,385	✗	▲	✓	
5.3	Elective Spells		25,968	10,468	8,329	2,259	✓	▲	✗	
5.4	Non-Elective Spells		28,660	12,568	9,601	2,488	✓	▼	✓	
5.5	OP Attendances / Procs (Total)		409,197	168,669	141,439	33,535	✓	▼	✗	
5.6	Outpatient DNA Rate		6%	6%	5.9%	5.9%	✓	▬	✓	
5.7	Virtual Outpatient Activity		25%	25%	13.8%	12.2%	✗	▼	✗	

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	142,109	119,419	30,665	✓	▼	✗	
7.2	Pay £'000		(215,539)	(89,964)	(80,480)	(19,985)	✗	▲	✓	
7.3	Non-pay £'000		(100,693)	(41,686)	(37,601)	(9,363)	✗	▲	✓	
7.4	Non-operating costs £'000		(44,713)	(9,970)	(7,237)	(1,782)	✓	▲	✓	
7.5	I&E Total £'000		0	489	(5,899)	(465)	✗	▲	✗	
7.6	Cash Balance £'000			24,366		17,224	✗	▼		
7.7	Savings Delivered £'000		17,335	7,223	599	547	✗	▲	✗	
7.8	Capital Expenditure £'000		(46,842)	(16,826)	(12,342)	(2,414)	✗	▼	✗	
7.9	Elective Spells (% of 2019/20 performance)		102%	102%	102.0%	96.9%	✗	▼	✓	
7.10	OP Attendances (% of 2019/20 performance)		112%	112%	105.8%	93.8%	✗	▼	✗	

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%		4.7%	✓	▲		
8.2	Agency Expenditure %		5.0%	5.0%	4.7%	3.1%	✓	▲	✓	
8.3	Staff Sickness % - Days Lost (Rolling 12 months) ✎		5.0%	5.0%		4.6%	✓	▲		
8.4a	Appraisals (excluding doctors)		90%	90%		93.0%	✓	▬		
8.5	Statutory Mandatory training		90%	90%		96.0%	✓	▲		
8.6	Substantive Staff Turnover		12.5%	12.5%		14.4%	✗	▲		

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		36	✗	▬		
O.2	Rebooked cancelled OPs - 28 day rule		90%	90%	76.2%	81.0%	✗	▼	✗	
O.4	Overdue Incidents >1 month		TBC	TBC		316	Not Available	▼		
O.5	Serious Incidents		75	32	10	0	✓	▲	✓	

Key: Monthly/Quarterly Change

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

YTD Position

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

Data Quality Assurance Definitions

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

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

OBJECTIVE 1 - PATIENT SAFETY

1.1 Mortality - HSMR (Rolling 15 months)

1.2 Mortality - SHMI (Rolling 15 months)

1.3 - Never events

1.4 - C.Diff Infections

1.5 - MRSA Bacteraemia

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

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

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

1.9- Duty of Candour Breaches

1.10 - E-Coli

1.11 - MSSA

1.12 - VTE Assessment

1.14 - Klebsiella Spp bacteraemia

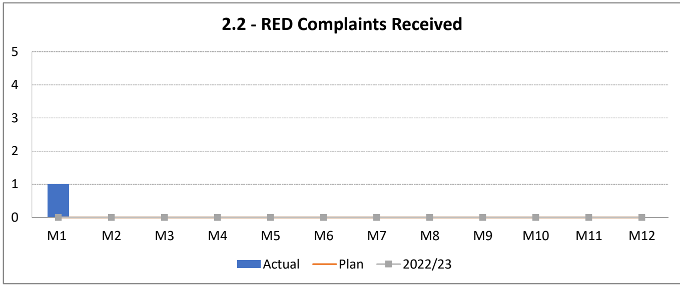
1.15 - P.aeruginosa bacteraemia

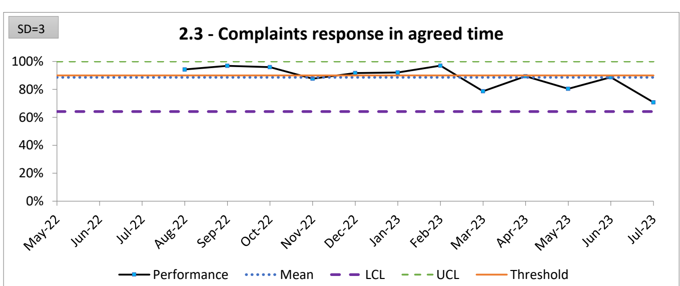
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

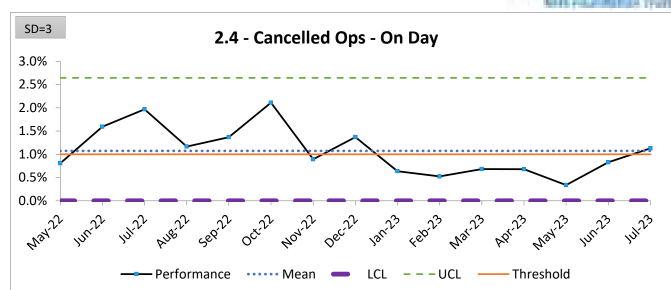
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

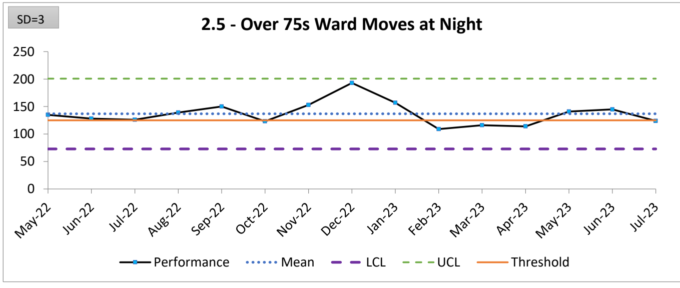
Board Performance Report 2023/24

OBJECTIVE 2 - PATIENT EXPERIENCE









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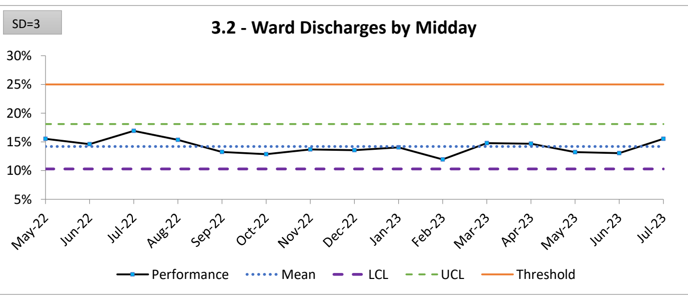
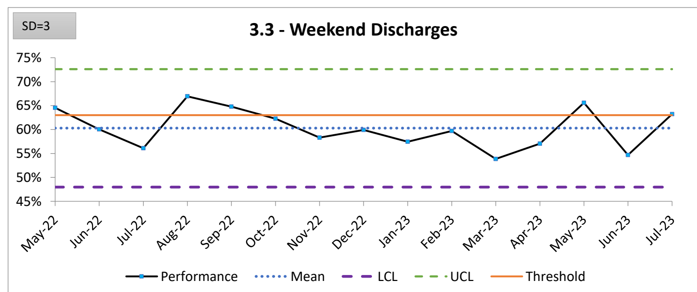
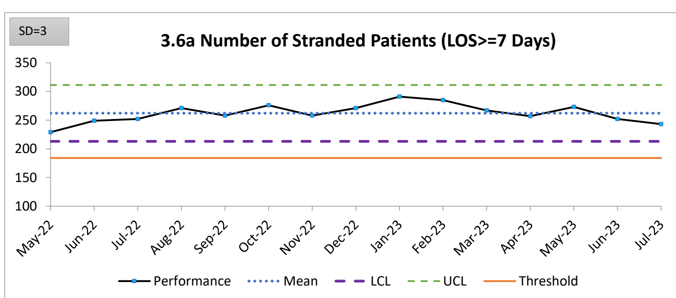
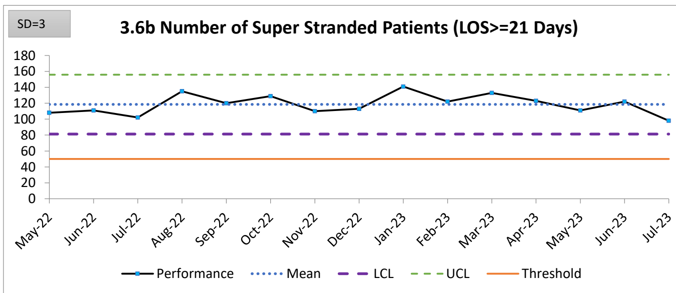
Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
Lower Control Limit (LCL)
Upper Control Limit
Targets/Thresholds/NHSI Trajectories

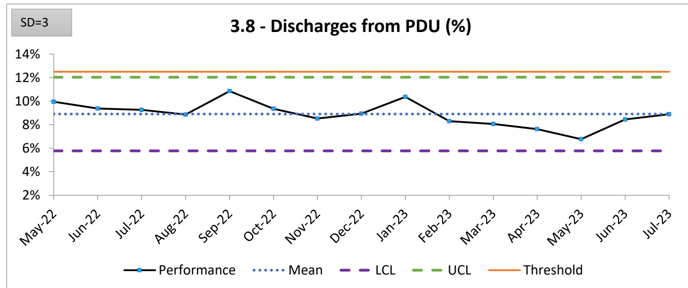
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

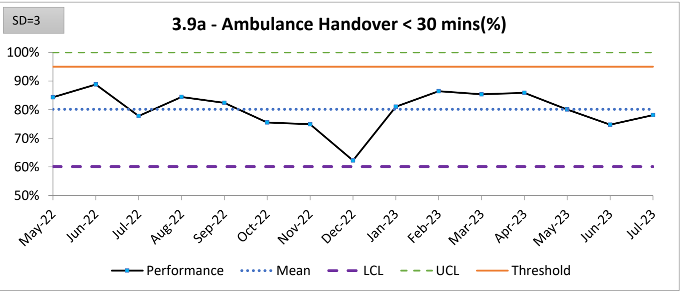


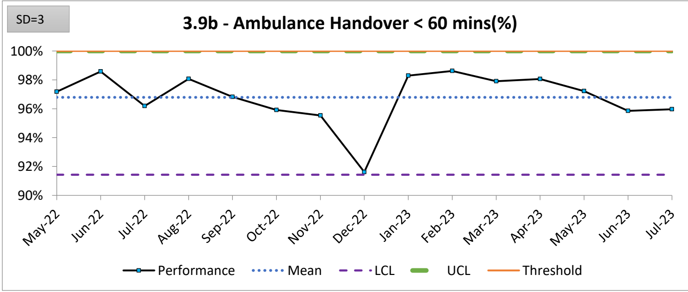












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Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
Lower Control Limit (LCL)
Upper Control Limit
Targets/Thresholds/NHSI Trajectories

Board Performance Report 2023/24

OBJECTIVE 4 - KEY TARGETS

SD=3
4.1a - ED Hour Target (includes UCS)

SD=3
4.1b - Total time in ED no more than 12 hours

SD=3
4.1c - Triage within 15 Minutes

SD=3
4.2 - RTT Incomplete Pathways <18 weeks

4.4 - RTT Total Open Pathways

4.5a - RTT Patients Waiting Over 52 weeks

4.5b - RTT Patients Waiting Over 65 weeks

SD=3
4.6 - Diagnostic Waits < 6 weeks

SD=3
4.7 - 2 Week Wait - Cancer

SD=3
4.8 - 31 day diagnosis to treatment - Cancer

SD=3
4.9 - 62 day standard - Cancer

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- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
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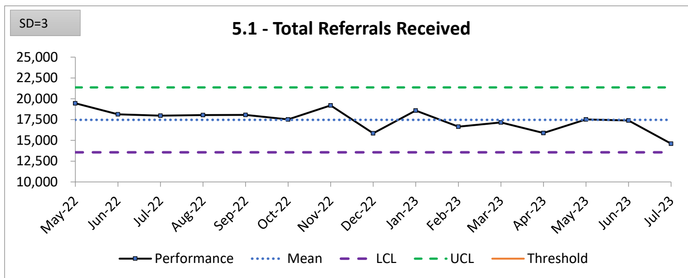
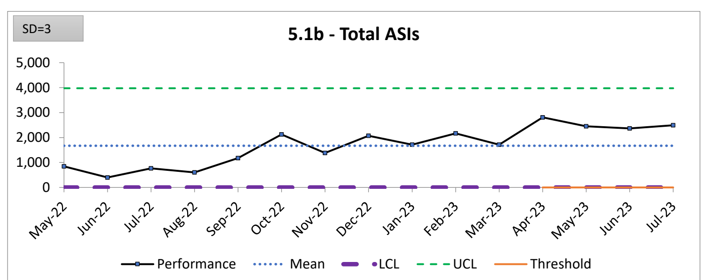
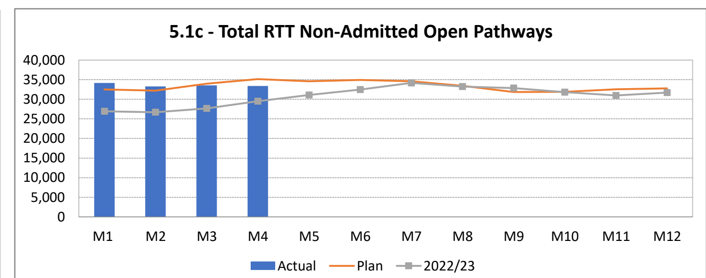
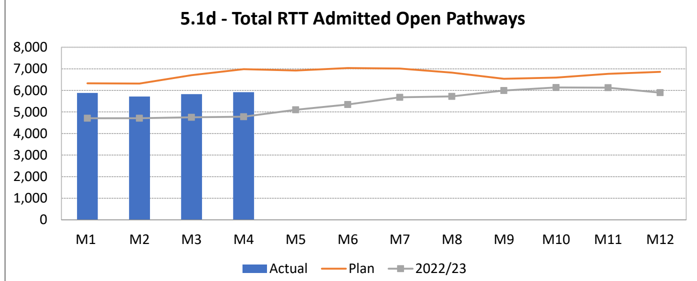
Board Performance Report 2023/24

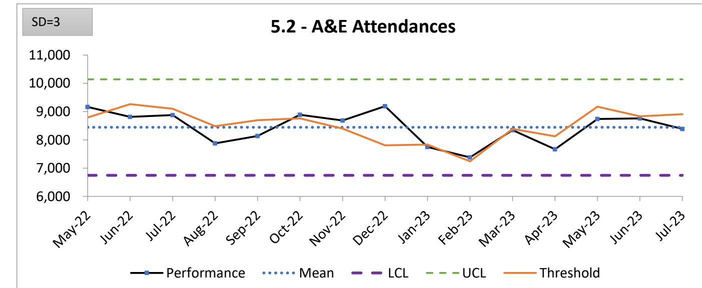
OBJECTIVE 5 - SUSTAINABILITY

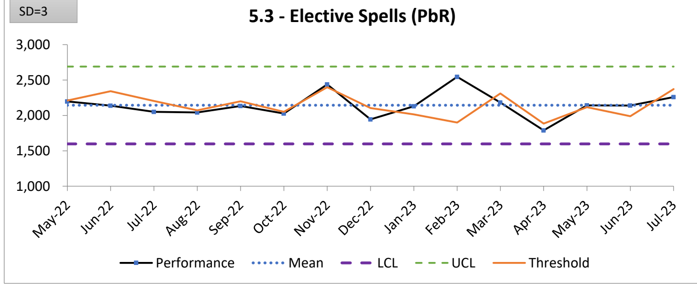


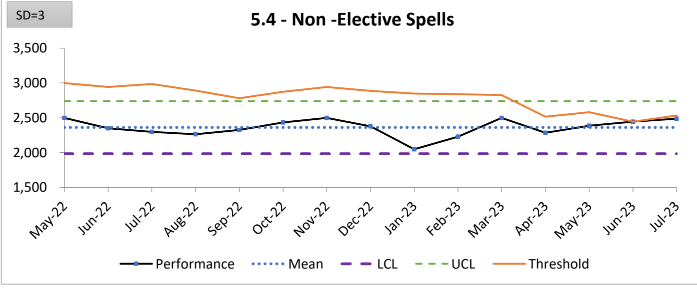


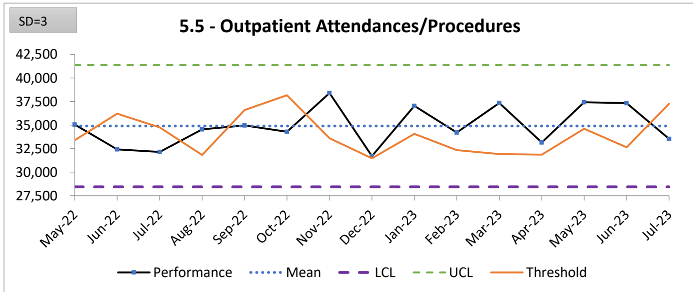


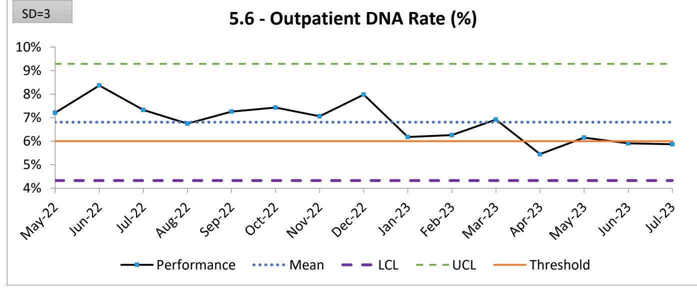












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Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
Lower Control Limit (LCL)
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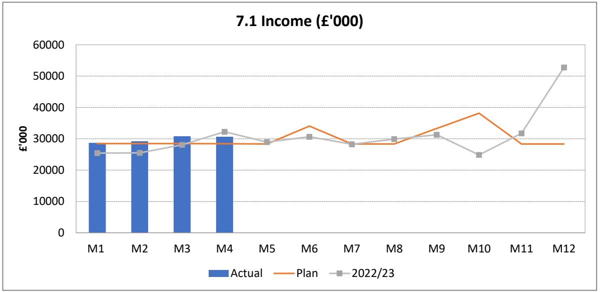
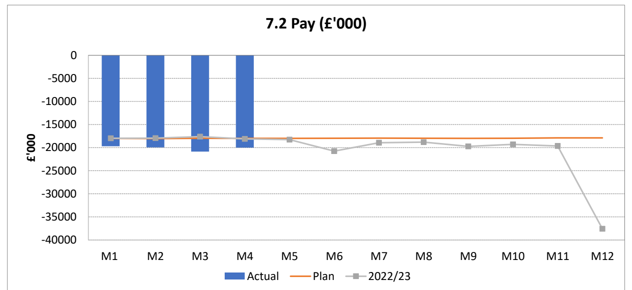
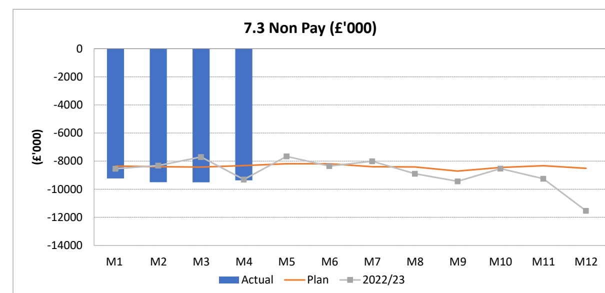
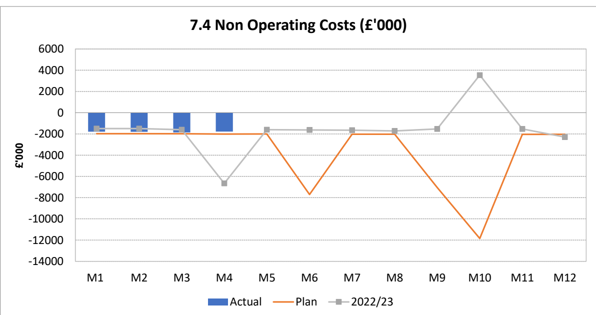
Board Performance Report 2023/24

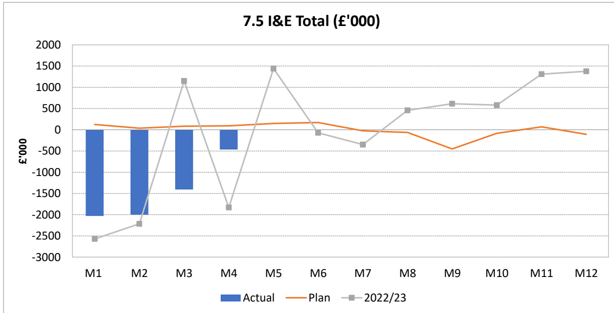
OBJECTIVE 7 - FINANCIAL PERFORMANCE

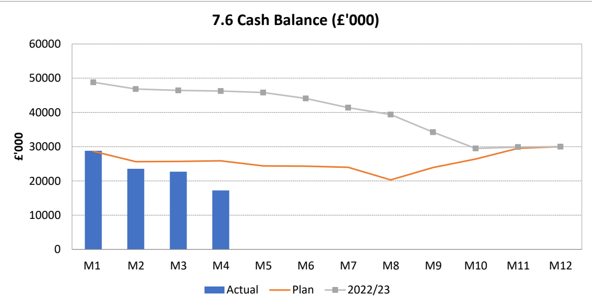


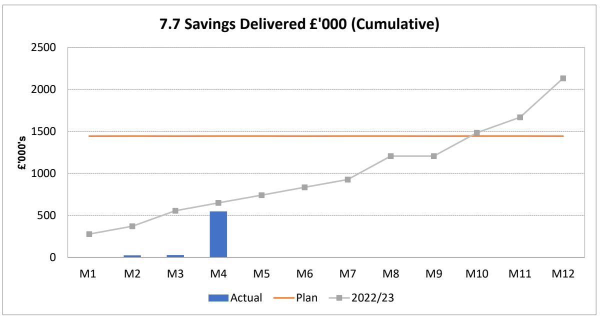


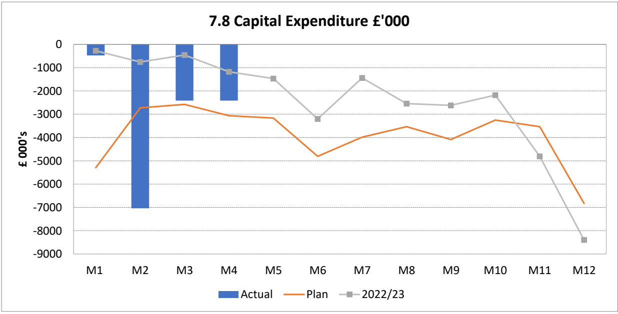


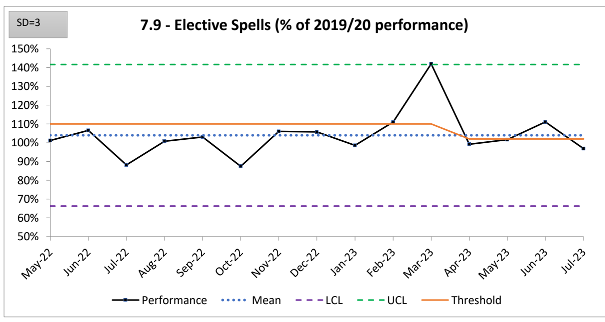


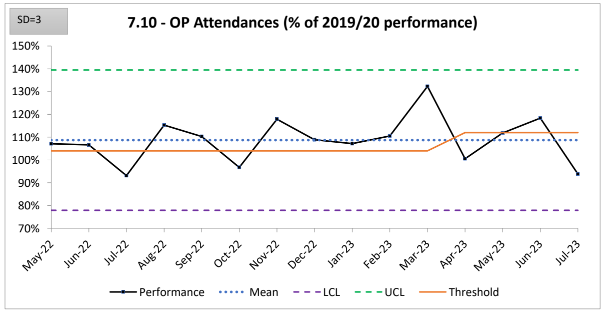












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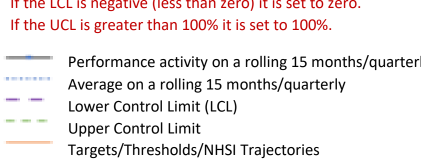
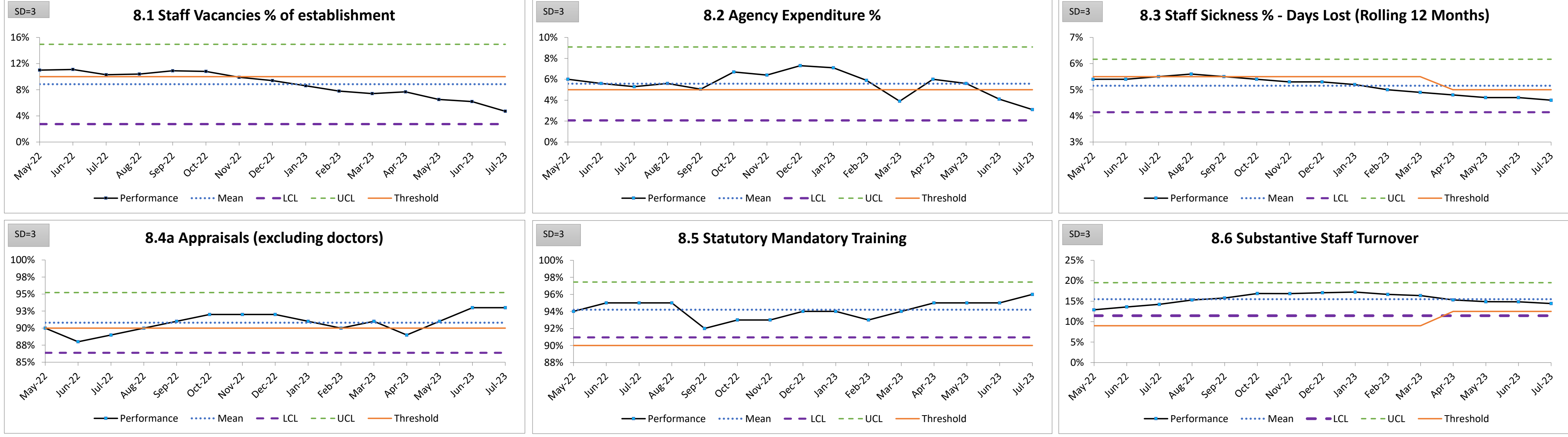


OBJECTIVE 8 - WORKFORCE PERFORMANCE



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Performance activity on a rolling 15 months/quarterly
Average on a rolling 15 months/quarterly
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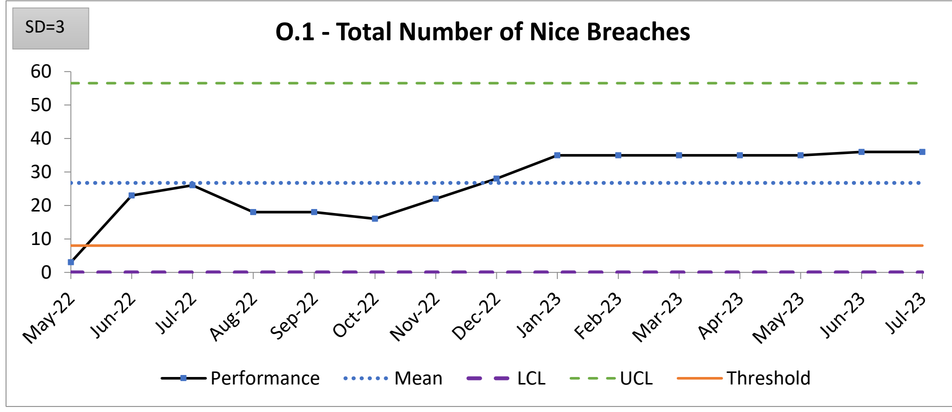

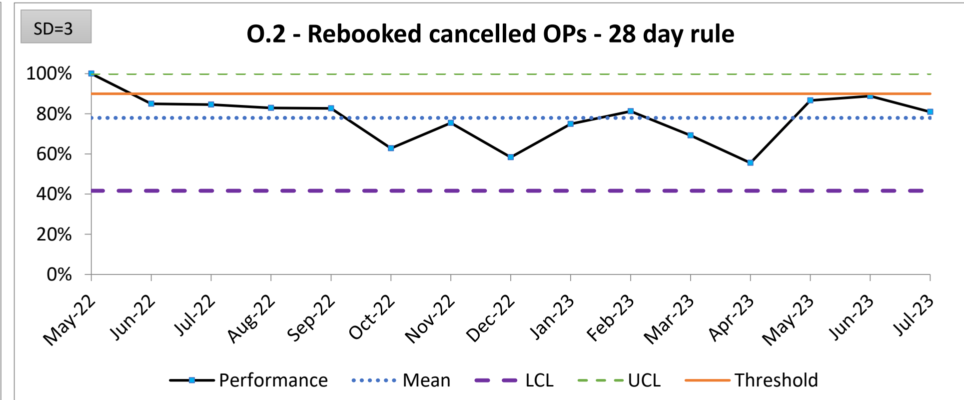

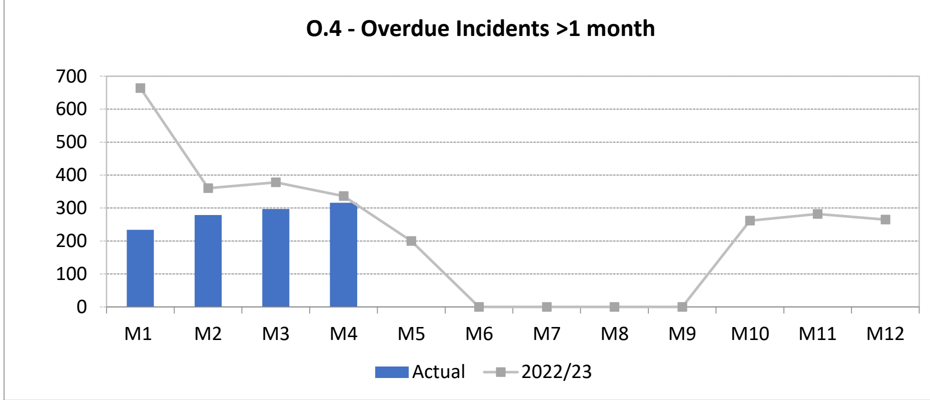

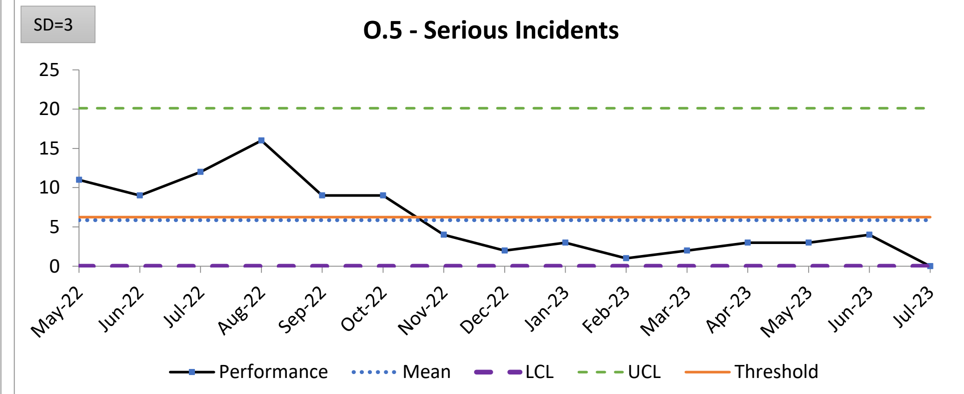

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Performance activity on a rolling 15 months/quarterly
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Meeting Title	Public Board	Date: 07 September 2023
Report Title	Finance Report - Month 4 2023-24	Agenda Item Number: 11
Lead Director	Terry Whittle	Director of Finance
Report Authors	Sue Fox Cheryl Williams	Head of Financial Management Head of Financial Control and Capital

Introduction	This report provides an update on the financial position of the Trust at Month 4 (July 23).					
Key Messages to Note	The Trust is reporting a £5.9m deficit (on a Control Total basis) to the end of the July 2023. This is £6.2m 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 but the run rate is improving as actions to reduce expenditure take effect. The savings target for the year is £17m (5% of expenditure). £5.8m of this was expected to be delivered to July. A low value of schemes was transacted during Q1, significant improvement has been made during July. The ERF actual delivery is currently above the new 104% target, but no over-performance has been recognised at Month 4 as per NHSE guidance. This will be recognised in next month's report (Month 5, August 2023)					
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 11-13

FINANCE REPORT FOR THE MONTH TO 31st JULY 2023

TRUST BOARD

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5	Capital	Page 7
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9	Appendices	Pages 11-13
10	Glossary of terms	Page 14

EXECUTIVE SUMMARY

(1 & 2.) Revenue – Clinical revenue for Integrated Care Board (ICB), NHSE contracts, and variable (non-ICB income) is above plan high-cost drugs over performance and additional allocated funding for Urgent and Emergency Care (UEC). Other revenue is above plan due principally to income received for education and training.

(3. & 4.) Operating expenses – Pay costs are higher than plan due to the cost of temporary staff working in escalation wards (£2.2m) and supernumerary staff covering new international recruits (£0.6m). Non-pay is above plan due to additional spend on drugs (£1.4m), clinical consumables in unfunded escalation areas (£1m) and clinical outsourcing (£1.3m). Slippage in the efficiency programme accounts for the balance.

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

(7.) Control Total Deficit - The Trust is reporting a £5.9m deficit to the end of July.

(8.) Industrial Action costs – Direct costs associated with cover during junior doctor and consultant strikes and estimated lost income because of cancellations.

(10.) Financial Efficiency – YTD schemes transacted of £0.6m, forecast of £17m made up of risk adjusted pipeline and non-recurrent mitigation. £2.3m was reported externally which is the value of the identified schemes.

(11.) Cash – Cash balance is £17.2m, equivalent to 19 days cash to cover operating expenses.

(12.) Capital – Capital expenditure is behind plan. This is due to a delay in committing to capital schemes due to the unresolved capital shortfall of £5m. The Trust received approval from the National Capital team for additional capital of £0.054m for LIMS (software system).

Measures

Ref	All Figures in £'000	Month 4 YTD Plan	Month 4 YTD Actual	Month 4 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	**Clinical Revenue**	107,741	110,108	2,367	323,224	323,224	(0)	
2	**Other Revenue**	7,508	9,310	1,803	42,168	42,168	-	
3	**Pay**	(73,624)	(80,480)	(6,856)	(220,501)	(220,501)	0	
4	**Non Pay**	(33,550)	(37,601)	(4,051)	(100,853)	(100,853)	-	
5	**Financing & Non-Ops**	(7,942)	(7,440)	502	(24,139)	(24,139)	-	
6	**Surplus/(Deficit)**	133	(6,102)	(6,235)	19,899	19,899	(0)	
7	**Control Total Surplus/(Deficit)**	357	(5,898)	(6,255)	0	-	(0)	

Memos

Ref	All Figures in £'000	Month 4 YTD Plan	Month 4 YTD Actual	Month 4 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
8	**IA Cost**	-	(966)	(966)	-	(1,339)	(1,339)	
9	**High Cost Drugs**	(7,689)	(8,214)	(525)	(23,048)	(23,048)	-	
10	**Financial Efficiency**	5,778	599	(5,179)	17,335	17,335	-	
11	**Cash**	25,861	17,224	(8,637)	29,995	29,995	-	
12	**Capital Plan**	(13,659)	(12,342)	1,317	(46,842)	(50,796)	(3,954)	

Key message
The Trust is reporting a £5.9m deficit (on a Control Total basis) to the end of the July 2023. This is £6.2m worse than plan.
There is a risk to achievement of the financial plan due to the continued pay cost burden from bank and premium agency costs to cover escalation areas, strike impact, vacancies, and supernumerary nursing arrangements.

ERF performance is currently above the new 104% target, but income has been recorded at planned levels to Month 4 as per NHSE guidance.

The capital expenditure programme is £1.3m below plan, due to the delay in resolving the capital shortfall. The Trust is awaiting approval for the £5m shortfall in the approved 23/24 ICS CDEL allocation.

FINANCIAL PERFORMANCE

2. **Summary Month 4**

Financial performance on a Control Total basis is a deficit of £5.9m YTD and £0.5m in month, against a break-even plan. Overspends on pay costs are partly offset by increased income.

3. Clinical Income
Clinical income shows a favourable variance of £2.4m YTD and £1.3m in-month. This is due to the income recognised for UEC and deferred income to support the current cost pressures as well as HCD over-performance.

4. Other Income
Other income shows a favourable variance of £1.8m YTD and £0.6m in month. The majority of this income variance is for education and training. This is offset by an equal and opposite adjustment in pay.

5. Pay
Pay spend is above plan by £6.8m YTD and £1.6m in month due partly to the cost of escalation and partly to unidentified cost improvements. Spend on temporary staffing costs has reduced slightly in month.

6. Non-Pay
Non-pay is above plan by £1m in month and £4m YTD due to increased spend on drugs and clinical consumables relating to both escalation areas and inflationary pressures.

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

	Month 4			Month 4 YTD			Plan		
All Figures in £'000	Plan	Actual	Var	Plan	Actual	Var	Plan	Forecast	Var
Clinical Revenue	26,935	28,261	1,326	107,741	110,108	2,367	323,224	323,224	(0)
Other Revenue	1,847	2,445	598	7,508	9,310	1,803	21,646	21,646	0
Total Income	28,782	30,706	1,924	115,249	119,418	4,169	344,870	344,870	(0)
Pay	(18,405)	(19,985)	(1,580)	(73,624)	(80,480)	(6,856)	(220,501)	(220,501)	0
Non Pay	(8,331)	(9,363)	(1,032)	(33,550)	(37,601)	(4,051)	(100,853)	(100,853)	0
Total Operational Expenditure	(26,736)	(29,347)	(2,612)	(107,174)	(118,080)	(10,906)	(321,354)	(321,354)	0
EBITDA	2,047	1,358	(688)	8,075	1,338	(6,737)	23,516	23,516	(0)
Financing & Non-Op. Costs	(1,954)	(1,824)	130	(7,718)	(7,236)	482	(23,516)	(23,516)	0
Control Total Deficit (excl. top ups)	**93**	**(465)**	**(558)**	**357**	**(5,898)**	**(6,255)**	**0**	**0**	**(0)**
Control Total Deficit (incl. top ups)	**93**	**(465)**	**(558)**	**357**	**(5,898)**	**(6,255)**	**0**	**0**	**(0)**
Donated income	0	(42)	(42)	0	0	0	20,522	20,522	0
Depreciation	(51)	(51)	0	(204)	(204)	0	(622)	(622)	0
Impairments & Rounding	0	0	0	(20)	0	20	(1)	(1)	0
Reported deficit/surplus	**42**	**(558)**	**(600)**	**133**	**(6,102)**	**(6,235)**	**19,899**	**19,899**	**(0)**

Key message
The financial position on a Control Total basis is a deficit of £5.9m YTD and £0.5m in month, 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 £1.4m in Month 4.

Deferred income of £2.3m has been released to date, broadly in-line with plan expectations.

CLINICAL INCOME

8. Block contracts

The Trust block contracts (c£241m) covers around 74% of the total clinical income, covering all activity except for planned care (covered by the elective recovery fund), diagnostic tests, high-cost drugs and devices, specialised chemotherapy activity, and the Community Diagnostic Centre (CDC).

9. Elective Recovery Fund

No income above planned levels has been recognised up to month 4 as per NHS England guidance. Planned care income is managed through the elective recovery fund (ERF) scheme. Below shows the YTD performance across the care types compared to the 2023/24 target, applying the ERF rules to the July (M04) SLAM indicative data. The Trust is validating local estimates for planned care activity against NHS England published data. This will be recognised in future months as per national guidance.

Activity:

Care Type	BASELINE	Target %	Target	YTD Target	YTD Performance	Over / under performance	Over / under performance %
Day Case	18,095	101.00%	18,276	5,911	7,718	1,807	130.58%
Elective	3,418	98.00%	3,350	1,129	1,077	-52	95.40%
Outpatients: New and procedures	169,735	107.00%	181,616	58,649	58,298	-351	99.40%
TOTAL	**191,248**	**104.00%**	**203,242**	**65,688**	**67,093**	**1,404**	**102.14%**
Outpatient Follow Ups	182,866	100.00%	182,866	63,036	81,573	18,537	129.41%

Finance:

Care Type	BASELINE	Target %	Target	YTD Target	YTD Performance	Over / under performance	Over / under performance %
Day Case	16,945,723	101.00%	17,115,180	5,445,425	6,055,919	610,494	111.21%
Elective	11,663,579	98.00%	11,430,307	4,183,973	3,701,680	-482,293	88.47%
Outpatients: New and procedures	33,765,233	107.00%	36,128,799	12,126,660	12,301,371	174,711	101.44%
TOTAL	**62,374,535**	**104.00%**	**64,674,287**	**21,756,057**	**22,058,970**	**302,912**	**101.39%**
Outpatient Follow Ups	32,737,373	100.00%	32,737,373	11,365,803	12,163,921	798,118	107.02%

The **day case** and **first attendances without procedures** care types are above the 2023/24 targets, for both finance and activity. The **elective inpatients** and **outpatient procedures** are reporting a material under performance, driven by less elective spells then plan, and outpatient procedures appearing as attendances. The position includes an accrual for the high volume of uncoded inpatient activity and uncoded procedures appearing as attendances.

Key message

No additional income above plan has been included for Elective Recovery Funding, in-line with NHSE guidance. Local estimates for ERF indicate overperformance to plan for the month 4 period. Actual values will be recognised in future months in-line with NHSE guidance.

EFFICIENCY SAVINGS

10. The efficiency target for 2023/24 is £17.3m. This equates to around 5% of expenditure for the year. The Trust has well established processes for the review and quality impact assessment of financial efficiency schemes prior to approval and implementation.

    The value of savings schemes transacted (budgets reduced) was low during quarter one (as reflected in the executive summary table on page 3), caused by delays progressing schemes due to competing priorities. Renewed priority was given during July and the table below reflects the latest position. £2.3m was reported externally (via the national PFR system) which represents 4/12ths of the £6.8m identified to date.

Division	Target	Current Status						Variance to Target
				Pipeline				
		Tracker Value	Green	Amber	Red	Total		
Medicine	3,450	569	465	130	23	1,187		(2,263)
Surgery	2,600	215	795	-	50	1,060		(1,540)
Womens and Childrens	1,400	870	545	35		1,450		50
Core Clinical	2,500	444	102	290	324	1,160		(1,340)
Corporate	2,385	122	1,862	-	-	1,984		(401)
Trustwide	5,000	-				-		(5,000)
Total	**17,335**	**2,220**	**3,769**	**455**	**397**	**6,841**		**(10,494)**

11. The risk-adjusted savings presented to date totals £6.8m. Further focus/progress is expected from the surgery division, and savings attributed to enhanced controls in temporary staffing and escalation beds are being quantified.

    Initial progress has been observed in agency expenditure controls as substantive staff fill has increased. Control processes are also on-track for WLI usage, outsourcing spend and escalation bed costs.

    Progress is required in the Surgery division and all pipeline schemes should be progressed to CIP QIA for review by the Quality Group. Additional Trust-wide schemes are expected to be reported in month 5.

    Assessment of the ERF income opportunity in the light of the revised ERF target of 104% is being assessed e.g., where additional activity delivers a contribution to the bottom-line.

Key message

The Trust has an efficiency requirement of £17.3m for the 2023/24 financial year. There is a significant shortfall against the year-to-date savings target at Month 4. Progress has been made during July with a risk adjusted position of £6.8m. The surgery division has been tasked with accelerating the value of savings schemes identified, and additional Trust-wide schemes will be quantified for Month 5. Based on current projections the Trust will need to non-recurrently mitigate a shortfall against the annual savings target to achieve the Control Total. A shortfall against the annual target will result in a pressure on the underlying Trust financial position.

CAPITAL - OVERVIEW YTD

12. The YTD spend to the end of July is £12.3m which is £1.3m 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

13. 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 £9.6m, an additional £0.054m from the previous month that relates to LIMS funding from South 4 Partnership to support the implementation of the new Laboratory information system. The Trust is awaiting approval for its IFRS16 lease funding of £2.4m and £0.1m for enabling fees for NHP. The current requested CDEL is £30.4m which includes ICS allocation, leases and nationally approved funding.

14. 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 £50.9m which includes the items waiting national approval for.

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

Funding Subcategory	ICS Required Funding 2023/24 Internally Funded	ICS Approved CDEL Allocation 2023/24 including bonus Internally Funded	National Approved CDEL Allocation 2023/24 Nationally funded	*Awaiting Approval CDEL 2023/24*	***Total CDEL inc awaiting approval***	Externally Funded Externally Funded	Total Capital
		£m	£m	*£m*	*£m*	£m	£m
Depreciation	18.27	13.27		*5.00*	18.27		
IFRS16				*2.36*	2.36		
PDC Funded National							
New Hospital Programme			1.16	*0.119*	*1.28*		
Digital Diagnostic Funding - Pathology			0.30		*0.30*		
Digital Diagnostic Funding - Imaging			0.33		*0.33*		
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	**18.27**	13.27	9.64	7.48	**30.39**		**30.39**
Donated Funding							
Council (Radiotherapy & CDC)						10.00	
Donor (Radiotherapy)						5.70	
Salix						4.82	
Total Donated Funding						**20.52**	**20.52**
Total Capital							**50.91**

Capital Item	Value of approved BC £m £m	23/24 YTD Mth 4 Plan £m	23/24 YTD Mth 4 Actual £m	YTD Variance to YTD Plan £m £m	Status
Pre-commitments from 22/23	**1.89**	**0.25**	**0.35**	**0.10**	
Scheme Allocations For 23/24 schemes (detailed below)	**7.07**	**3.12**	**3.76**	**0.64**	
CBIG including IT and Contingency	3.14	0.64	0.35	-0.29	
Strategic Radiotherapy	1.91	0.65	0.60	- 0.05	
Strategic Salix	1.99	0.17	0.13	- 0.03	
Strategic Contingency Allocated	0.03		0.03	0.03	
Hospital capacity (Build & Fees)		0.00	0.00	0.00	
Funding to be allocated	0.00	1.67	0.00	-1.67	
Adjustment			2.65	2.65	
(ICS CDEL Requested)	**8.95**	**3.37**	**4.11**	**0.74**	
Nationally approved schemes (detailed below)	**8.68**	**2.64**	**2.52**	**- 0.13**	
NHP	1.16	0.38	0.28	- 0.11	
Digital Diagnostic Funding -Pathology	0.36	0.00	0.03	0.03	
Digital Diagnostic Funding - Imaging	0.00	0.00	0.00	-	
CDC - Lloyds Court & Whitehouse Park	3.95	2.26	2.21	- 0.05	
Imaging Transformation - CT Scanner	0.90	0.00	0.00	-	
UEC (supporting Hospital Capacity Schemes)	2.31	0.00	0.00	0.00	
CDEL Submitted capital plan	**17.63**	**6.02**	**6.63**	**0.61**	
New Leases Impact under IFRS 16 - held centrally	2.36	2.32	2.32	0.00	
Submitted CDEL capital plan	**20.00**	**8.34**	**8.95**	**0.61**	
Donated Funded Schemes (excluded from CDEL)	20.52	5.32	3.39	- 1.93	-
Total Capital spend	**40.52**	**13.66**	**12.34**	**-1.32**	

CASH

16. <u>Summary of Cash Flow</u>
    The cash balance at the end of July was £17.2m, £8.8m lower than the planned figure of £26m and a £5.5m decrease on last month's figure of £22.7m (see opposite).

17. <u>Cash arrangements 2023/24</u>
    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.

18. <u>Better Payment Practice</u>
    The Trust has fallen below the national target of 95% of all bills paid within the target in terms of value and volume. This is 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 M4 YTD Number	Actual M4 YTD £'000	Actual M3 YTD Number	Actual M3 YTD £'000
Non NHS				
Total bills paid in the year	24,900	68,598	17,607	49,210
Total bills paid within target	22,308	63,814	15,524	45,156
Percentage of bills paid within target	**89.6%**	**93.0%**	**88.2%**	**91.8%**
NHS				
Total bills paid in the year	636	3,155	472	1,646
Total bills paid within target	500	1,181	373	776
Percentage of bills paid within target	**78.6%**	**37.4%**	**79.0%**	**47.1%**
Total				
Total bills paid in the year	**25,536**	**71,753**	**18,079**	**50,855**
Total bills paid within target	**22,808**	**64,995**	**15,897**	**45,932**
Percentage of bills paid within target	**89.3%**	**90.6%**	**87.9%**	**90.3%**

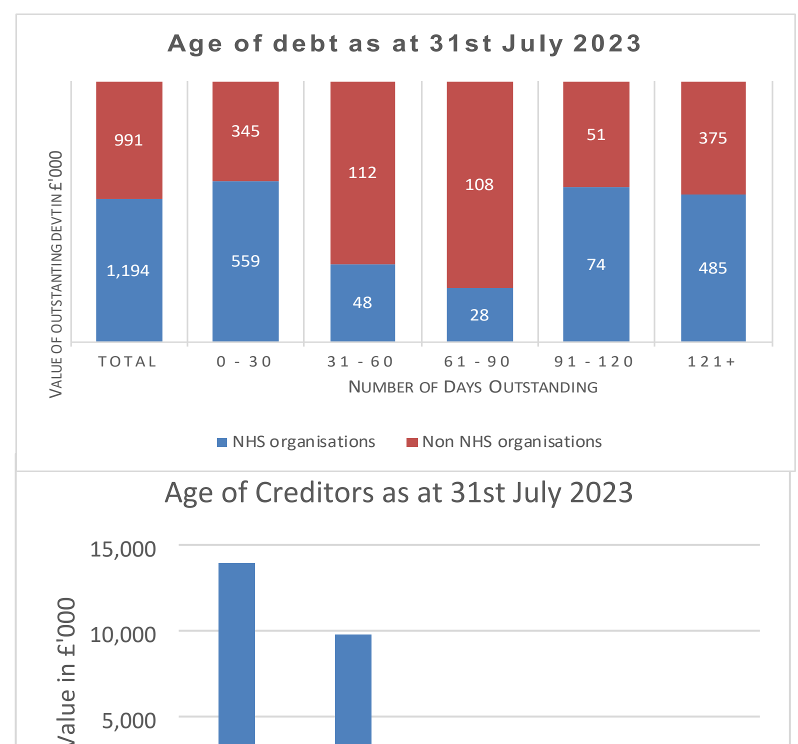
Key message
Cash at the end of May was behind plan at £17.2m. The Trust has fallen below the 95% target for BPPC, due to issues experienced by SBS during their repatriation of Accounts Payable (AP) services, and ongoing agency invoicing issues. Management is working to rectify payment performance to levels required.

BALANCE SHEET

19. Statement of Financial Position

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

- Non-Current Assets have increased from March 23 by £6.8m; this is driven by capital purchases in year offset by in year depreciation.
- Current assets have decreased by £11.2m; this is due to the decrease in cash £12.8m.
- Current liabilities have decreased by £0.9m; this is due to the increase in trade payables £1.9m and a £2.2m decrease in Deferred Income.
- Non-Current Liabilities have increased from March 23 by £2.6m; this is due to the Right of Use assets, related to IFRS 16.



20. Aged debt

- The debtors position as of July 23 is £2.2m, which is an increase of £0.3m from the prior month. Of this total £0.8m is over 121 days old.
- The three largest NHS debtors are, CNWL £0.1m relating to salary, parking and utilities 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, £2.2m with Medical Property Ltd for utility recharges and £2.2m NHS Property Services re utility recharges.

21. Creditors

- The creditors position as of July 23 is £13.9m, which is an increase of £5.0m from the prior month. Of this, £4.2m is over 30 days with £2.6m approved for payment.

Key message

Main movements in year on the statement of financial position are the reduction in cash of £12.8m, the non-current assets increase of £6.8m, and the non-current liabilities increase of £2.6m.

RECOMMENDATIONS TO BOARD

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

Appendix 1

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

	FY23	M4 CUMULATIVE			M4			PRIOR MONTH	
	Annual Budget £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	M3 Actual £'000	Change £'000
INCOME									
Outpatients	50,893	16,678	16,200	(478)	4,459	4,001	(458)	4,375	(374)
Elective admissions	31,551	10,175	10,347	172	2,841	2,386	(456)	3,282	(896)
Emergency admissions	84,791	30,263	30,250	(13)	7,590	7,589	(1)	8,540	(951)
A&E	19,738	6,610	6,610	0	1,661	1,661	(0)	1,660	1
Other Admissions	2,168	711	710	(1)	(2,812)	184	2,996	165	19
Maternity	20,418	6,478	6,474	(4)	4,379	1,382	(2,997)	1,491	91
Critical Care & Neonatal	6,713	2,099	2,099	(0)	566	566	0	415	151
Imaging	6,815	2,086	2,086	0	539	539	0	412	127
Direct access Pathology	5,792	1,785	1,785	(0)	461	461	0	363	98
Non Tariff Drugs and Devices (high cost/individual drugs)	21,142	6,696	6,699	3	1,696	1,439	(257)	1,734	(295)
Other (inc. home visits and best practice tariffs)	5,985	1,632	4,319	2,687	(463)	2,035	2,498	(393)	2,428
National Block/Top up	67,611	22,528	22,528	(0)	5,819	5,819	0	6,255	(436)
Clinical Income	**323,224**	**107,741**	**110,108**	**2,367**	**26,935**	**28,261**	**1,326**	**28,298**	**(37)**
Non-Patient Income	21,646	7,508	9,310	1,803	1,847	2,444	597	2,484	(40)
Donations	20,522	0	0	0	0	(42)	(42)	42	(84)
Non-Patient Income	**42,168**	**7,508**	**9,310**	**1,803**	**1,847**	**2,403**	**556**	**2,526**	**(123)**
TOTAL INCOME	**365,392**	**115,249**	**119,418**	**4,169**	**28,782**	**30,664**	**1,882**	**30,824**	**(161)**
EXPENDITURE									
Pay - Substantive	(199,957)	(66,682)	(67,260)	(578)	(16,687)	(17,025)	(338)	(17,586)	562
Pay - Bank	(11,201)	(3,665)	(6,619)	(2,954)	(920)	(1,612)	(693)	(1,701)	89
Pay - Locum	(2,957)	(1,010)	(2,476)	(1,466)	(250)	(604)	(354)	(662)	59
Pay - Agency	(5,594)	(2,019)	(3,781)	(1,763)	(491)	(630)	(139)	(884)	254
Pay - Other	(821)	(274)	(344)	(70)	(68)	(114)	(46)	(72)	(42)
Pay CIP	41	14	0	(14)	3	0	(3)	0	0
Vacancy Factor	69	11	0	(11)	8	0	(8)	0	0
Pay	**(220,501)**	**(73,624)**	**(80,480)**	**(6,856)**	**(18,405)**	**(19,985)**	**(1,580)**	**(20,866)**	**881**
Non Pay	(77,805)	(25,861)	(29,387)	(3,526)	(6,393)	(7,119)	(726)	(7,415)	296
Non Tariff Drugs (high cost/individual drugs)	(23,048)	(7,689)	(8,214)	(525)	(1,938)	(2,244)	(306)	(2,092)	(152)
Non Pay	**(100,853)**	**(33,550)**	**(37,601)**	**(4,051)**	**(8,331)**	**(9,363)**	**(1,032)**	**(9,507)**	**144**
TOTAL EXPENDITURE	**(321,354)**	**(107,174)**	**(118,080)**	**(10,906)**	**(26,736)**	**(29,347)**	**(2,612)**	**(30,373)**	**1,026**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**44,038**	**8,075**	**1,338**	**(6,737)**	**2,047**	**1,316**	**(730)**	**451**	**865**
Interest Receivable	360	120	494	374	30	112	82	115	(3)
Interest Payable	(687)	(229)	(235)	(6)	(57)	(59)	(2)	(59)	0
Depreciation, Impairments & Profit/Loss on Asset Disposal	(16,622)	(5,440)	(5,304)	136	(1,379)	(1,329)	51	(1,323)	(6)
Donated Asset Depreciation	(622)	(204)	(204)	0	(51)	(51)	0	(51)	0
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0	0
DEL Impairments	(560)	(187)	(187)	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**	**2,135**	**(4,098)**	**(6,233)**	**542**	**(57)**	**(600)**	**(914)**	**856**
Dividends Payable	(6,007)	(2,002)	(2,004)	(2)	(501)	(501)	(0)	(501)	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**19,900**	**133**	**(6,102)**	**(6,235)**	**42**	**(558)**	**(600)**	**(1,415)**	**856**

Appendix 2

Statement of Cash Flow
As of 31st July 2023

	Mth12 2022-23 £000	Mth 4 £000	Mth 3 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit) from continuing operations	(2,225)	(4,170)	(4,106)	(64)
Operating (deficit)	**(2,225)**	**(4,170)**	**(4,106)**	**(64)**
Non-cash income and expense:				
Depreciation and amortisation	14,941	5,508	4,128	1,380
Impairments	1,899	0	0	0
(Increase)/Decrease in Trade and Other Receivables	(8,203)	(1,628)	2,035	(3,663)
(Increase)/Decrease in Inventories	(1,096)	9	10	(1)
Increase/(Decrease) in Trade and Other Payables	(7,239)	(2,619)	(3,369)	750
Increase/(Decrease) in Other Liabilities	(1,935)	(2,111)	(1,345)	(766)
Increase/(Decrease) in Provisions	420	(18)	(14)	(4)
NHS Charitable Funds	(181)	0	(42)	42
Other movements in operating cash flows	1,730	(2)	(5)	3
NET CASH GENERATED FROM OPERATIONS	**(1,889)**	**(5,031)**	**(2,708)**	**(2,323)**
Cash flows from investing activities				
Interest received	871	494	382	112
Addition of ROU assets	(40)	0	0	0
Purchase of intangible assets	(2,673)	5,781	6,605	(824)
Purchase of Property, Plant and Equipment	(25,097)	(14,532)	(13,317)	(1,215)
Net cash generated (used in) investing activities	**(26,939)**	**(8,257)**	**(6,330)**	**(1,927)**
Cash flows from financing activities				
Public dividend capital received	8,040	0	0	0
Capital element of finance lease rental payments	(2,235)	939	1,992	(1,053)
Unwinding of discount	0	(187)	(139)	(48)
Interest element of finance lease	(378)	(235)	(176)	(59)
PDC Dividend paid	(4,760)	0	0	0
Receipt of cash donations to purchase capital assets	181	0	42	(42)
Net cash generated from/(used in) financing activities	**848**	**517**	**1,719**	**(1,202)**
Increase/(decrease) in cash and cash equivalents	**(27,980)**	**(12,771)**	**(7,319)**	**(5,452)**
Opening Cash and Cash equivalents	**57,975**	**29,995**	**29,995**	
Closing Cash and Cash equivalents	**29,995**	**17,224**	**22,676**	**(5,452)**

Appendix 3

Statement of Financial Position as of 31st July 2023

	Mar-23 Audited	Jul-23 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	204.3	210.4	6.1	3.0%
Intangible Assets	19.6	18.8	(0.8)	(4.1%)
ROU Assets	24.4	25.9	1.5	6.1%
Other Assets	3.3	3.3	0.0	0.0%
Total Non Current Assets	**251.6**	**258.4**	**6.8**	**2.7%**
Assets Current				
Inventory	5.2	5.1	(0.1)	(1.9%)
NHS Receivables	9.8	5.1	(4.7)	(48.0%)
Other Receivables	6.0	12.4	6.4	106.7%
Cash	30.0	17.2	(12.8)	(42.7%)
Total Current Assets	**51.0**	**39.8**	**(11.2)**	**(22.0%)**
Liabilities Current				
Interest -bearing borrowings	(1.8)	(1.2)	0.6	(33.3%)
Deferred Income	(18.0)	(15.8)	2.2	(12.2%)
Provisions	(2.8)	(2.8)	0.0	0.0%
Trade & other Creditors (incl NHS)	(51.5)	(53.4)	(1.9)	3.7%
Total Current Liabilities	**(74.1)**	**(73.2)**	**0.9**	**(1.2%)**
Net current assets	**(23.1)**	**(33.4)**	**(10.3)**	**44.6%**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(22.7)	(25.3)	(2.6)	11.5%
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	**(25.5)**	**(28.1)**	**(2.6)**	**10.2%**
Total Assets Employed	**203.0**	**196.9**	**(5.8)**	**(2.8%)**
Taxpayers Equity				
Public Dividend Capital (PDC)	283.2	283.2	0.0	0.0%
Revaluation Reserve	60.5	60.5	0.0	0.0%
Financial assets at FV through OCI reserve	(2.6)	(2.6)	0.0	0.0%
I&E Reserve	(138.1)	(144.2)	(6.1)	4.4%
Total Taxpayers Equity	**203.0**	**196.9**	**(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 recovery of elective care backlogs
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: September 2023
Report Title	**Workforce Report – Month 4**	**Agenda Item Number: 12**
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 July 2023 (Month 4) 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 July (Month 4), covering the preceding 13 months.

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

Indicator	Measure	Target	07/2022	08/2022	09/2022	10/2022	11/2022	12/2022	01/2023	02/2023	03/2023	04/2023	05/2023	06/2023	07/2023
Staff in post *(as at report date)*	Actual WTE		3445.6	3437.0	3458.0	3467.9	3507.1	3524.8	3572.5	3605.1	3618.5	3636.0	3697.4	3710.4	**3776.8**
	Headcount		3930	3917	3946	3956	4001	4018	4075	4107	4142	4165	4206	4222	**4293**
Establishment *(as per ESR)*	WTE		3840.8	3837.0	3881.4	3887.9	3892.8	3892.4	3908.4	3909.8	3907.7	3951.1	3956.4	3956.0	**3963.2**
	%, Vacancy Rate - Trust Total	**10.0%**	10.3%	10.4%	10.9%	10.8%	9.9%	9.4%	8.6%	7.8%	7.4%	8.0%	6.5%	6.2%	**4.7%**
	%, Vacancy Rate - Add Prof Scientific and Technical		35.2%	32.4%	31.3%	33.7%	32.2%	32.5%	32.7%	33.2%	33.2%	31.2%	24.4%	24.4%	**25.6%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA** s)*		4.3%	3.3%	10.1%	10.7%	11.2%	9.0%	12.2%	11.3%	7.7%	9.3%	6.4%	5.3%	**0.3%**
	%, Vacancy Rate - Administrative and Clerical		8.5%	8.4%	8.1%	8.8%	7.6%	7.5%	5.5%	5.4%	5.0%	4.3%	3.0%	3.0%	**2.8%**
	%, Vacancy Rate - Allied Health Professionals		20.2%	18.8%	18.9%	17.8%	16.7%	16.4%	13.6%	12.7%	12.0%	13.6%	16.5%	17.4%	**17.1%**
	%, Vacancy Rate - Estates and Ancillary		14.3%	12.9%	11.5%	10.4%	9.0%	9.5%	8.3%	8.3%	8.6%	11.9%	8.4%	7.2%	**6.2%**
	%, Vacancy Rate - Healthcare Scientists		0.8%	0.0%	0.0%	0.7%	0.0%	1.8%	4.0%	1.7%	1.7%	1.8%	6.3%	9.3%	**6.2%**
	%, Vacancy Rate - Medical and Dental		0.0%	2.8%	0.0%	0.0%	0.0%	0.0%	0.7%	0.8%	3.9%	2.9%	0.0%	0.0%	**0.0%**
	%, Vacancy Rate - Nursing and Midwifery Registered		15.5%	15.3%	15.3%	14.6%	12.8%	12.2%	9.3%	7.4%	7.1%	7.9%	7.7%	7.1%	**7.6%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		14.3%	14.5%	14.8%	15.1%	15.3%	15.6%	15.7%	15.7%	15.3%	15.3%	15.3%	15.1%	**14.8%**
	%, Temp Staff Usage (%, WTE)		14.0%	14.1%	14.2%	14.4%	14.4%	14.5%	14.5%	14.5%	14.5%	14.3%	14.3%	14.2%	**14.0%**
Absence (12 months)	%, 12 month Absence Rate	**5.0%**	5.6%	5.5%	5.4%	5.3%	5.3%	5.2%	5.0%	4.9%	4.8%	4.7%	4.7%	**4.6%**	*4.5%*
	- %, 12 month Absence Rate - Long Term		*2.9%*	*2.9%*	*2.8%*	*2.6%*	*2.6%*	*2.5%*	*2.5%*	*2.4%*	*2.4%*	*2.4%*	*2.4%*	***2.4%***	*2.4%*
	- %, 12 month Absence Rate - Short Term		*2.7%*	*2.6%*	*2.6%*	*2.7%*	*2.7%*	*2.7%*	*2.5%*	*2.5%*	*2.4%*	*2.3%*	*2.3%*	***2.2%***	*2.1%*
	%,In month Absence Rate - Total		5.6%	4.1%	4.2%	5.0%	4.7%	5.0%	4.1%	4.0%	4.1%	4.0%	3.9%	**3.9%**	*4.2%*
	- %, In month Absence Rate - Long Term		*2.6%*	*2.5%*	*2.3%*	*2.3%*	*2.6%*	*2.7%*	*2.4%*	*2.5%*	*2.2%*	*2.3%*	*2.3%*	***2.5%***	*2.4%*
	- %, In month Absence Rate - Short Term		*3.0%*	*1.6%*	*1.9%*	*2.7%*	*2.1%*	*2.3%*	*1.7%*	*1.5%*	*1.9%*	*1.6%*	*1.6%*	***1.4%***	*1.8%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters (In-month)		50.9	55.0	59.4	49.2	49.1	54.1	65.5	52.5	61.8	46.8	62.6	44.0	**73.3**
	Headcount, Starters (In-month)		57	58	68	58	55	60	76	55	65	53	71	52	**83**
	WTE, Leavers (In-month)		50.3	46.1	52.9	51.2	27.9	41.7	41.6	25.2	45.3	22.6	25.4	33.8	**41.8**
	Headcount, Leavers (In-month)		60	58	60	62	35	48	48	29	52	27	30	40	**47**
	%, Leaver Turnover Rate (12 months)	**12.5%**	14.2%	15.3%	15.8%	16.9%	16.9%	17.1%	17.2%	16.7%	16.4%	15.3%	14.9%	14.9%	**14.4%**
Statutory/Mandatory Training	%, Compliance	**90%**	95%	95%	92%	93%	93%	94%	94%	93%	94%	95%	95%	95%	**96%**
Appraisals	%, Compliance	**90%**	89%	90%	91%	92%	92%	92%	91%	90%	91%	89%	91%	93%	**93%**
Time to Hire (days)	General Recruitment	**35**	59	64	56	54	53	48	50	43	41	43	51	49	**50**
	Medical Recruitment (excl Deanery)	**35**	89	72	73	63	80	33	67	59	87	78	70	75	**49**
Employee relations	Number of open disciplinary cases		13	14	15	22	26	22	24	23	20	19	19	13	**13**

2.1. **Temporary staffing usage** has gradually reduced over the past 4 months, now sitting at 14% with a 0.9% improvement in cost. Work continues to ensure scrutiny of all agency spend, with detailed requests for agency being signed off by the Executive Lead prior to booking. The electronic request form for agency was implemented at the end of M4.

2.2. The Trust's **headcount continues to increase** and there are now 4293 employees in post in the Trust, which is the highest it has been, with an additional 363 staff in post compared to the same period in the previous year. The **vacancy rate** continues to decrease and is currently at **4.7%** with improvements across several staff groups.

2.3. **Staff absence is at 4.5%** with a slight increase in month due to a rise in short term absence. Managers continue to support staff back to work in line with our sickness absence and attendance policy.

2.4. **Staff turnover** continues to make improvements with a **decrease down to 14.4%**, its lowest point for 12 months. Retention projects in areas of high turnover continue and the work is being monitored through Workforce Development and Assurance Committee.

2.5. **Time to hire** has increased to 50 days and is likely to be further impacted as problems with the national recruitment systems following a software update led to intermittent closure of the national Trac recruitment system during M4. This is likely to have an ongoing impact on time to hire for the next few months.

2.6. The number of **open disciplinary cases** has reduced with several hearings taking place in M3 and M4. A detailed Employee Relations case report is produced monthly to JCNC, an annual report is presented to Workforce Development and Assurance Committee, and a quarterly report is presented at Workforce Board.

2.7. **Statutory and mandatory training** compliance is at 96% and **appraisals** compliance is at 93%.

2.8. There are **59.3 nursing vacancies** across the Trust. The fourth cohort of the 2023 intake of internationally educated nurses arrived in M4, consisting of 22 nurses. There are currently 23 international and 17 domestic nurses in the recruitment pipeline.

2.9. There are **88 HCSW vacancies** (B2 and B3 and including Maternity Support Workers) across the Trust which is a decrease of 12 on the previous month. There are currently **11 candidates** in the recruitment pipeline at offer stage with a further **300 applications** for the remaining posts. The collaborative recruitment campaign with Bedfordshire Hospitals as part of a BLMK initiative has been very positive. The HCSW Steering Group is identifying ways of improving onboarding and training for this staff group to better support retention.

3. Continuous Improvement, Transformation and Innovation

3.1. The **HR Services Team** will be launching the next set of electronic forms, specifically the escalated agency rate forms, in M6 as part of its ongoing commitment to reduce paper and automate HR processes, making improvements and streamlining process for employees and managers.

3.2. The last cohort of international nurses arrive in M6. This will be the final cohort at the end of the two year project which will have seen the onboarding of 225 internationally trained nurses for the Trust. A **Career Coach** will be joining the Education Team in the next quarter to support the career progression of our internationally trained nurses and midwives. This will support retention as well as ensuring we are harnessing talent and deploying our staff to areas that align with their skills, interests, and longer term career goals.

4. Culture and Staff Engagement

4.1. The **MKWay for Managers** now has new foundation modules available for leaders with management responsibility, specifically carrying out investigations and presenting and chairing hearings. Further management modules are being developed, specifically around management style, introspection and reflection, flexibility in leadership, and leading conversations with care.

4.2. The **Staff Survey** is due to launch in M7 as part of the Trust's annual Protect and Reflect Event, with Covid and Flu Vaccinations being offered to staff whilst they complete their survey. This year and ESR data census will also take place as part of Protect and Reflect.

5. Current Affairs & Hot Topics

5.1. The revised NHS **Fit and Proper Person Test Framework** was published in M5 and the Trust has updated its policy to ensure that recruitment and assessment of its Board Members is comprehensive and compliant. The implementation date for the revised processes is 30 September 2023.

5.2. The Trust's **Freedom to Speak Up** (FTSU) Policy has been reviewed to ensure that it is compliant with the national framework and template policy. The 3-year strategy for FTSU is currently being reviewed, with recruitment underway for additional FTSU Champions, as well as the planned implementation of the FTSU App for staff, giving them an additional mode of contacting the FTSU Team.

6. Recommendations

6.1. Members are asked to note the report.

Meeting Title	MHUK Trust Board	Date: September 2023
Report Title	**Revalidation Quality Assurance and Framework**	**Agenda Item Number: 13**
Lead Director	*Dr Ian Reckless* *Medical Director and Responsible Office*	
Report Author	*Mrs Rosie Sampson* *Business Manager, MDO*	

Introduction	*Annual statement of compliance regarding appraisal and revalidation performance at MKUH.*		
Key Messages to Note	*The Trust maintains robust processes to support doctors through their appraisals and revalidation. This annual audit did not identify any concerning trends.*		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** Y	**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	*N/A*
Next Steps	*Due for submission to NHSE following Board approval.*
Appendices/Attachments	*N/A*

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The Board of Milton Keynes University Hospital NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Continue with regional RO events Comments: Yes Action for next year: Continue to attend and engage with regional RO events

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: None Comments: The Trust employs a multidimensional team to support appraisal and revalidation across the organisation Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Yes Comments: None Action for next year: Yes

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None Comments: Yes, Trust policies are reviewed on a monitored schedule Action for next year: None

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: None Comments: Yes Action for next year: None

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: None Comments: Yes Action for next year: None

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1] Action from last year: None Comments: Yes Action for next year: None

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: None

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Comments: Yes

Action for next year: None

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None

Comments: Yes. Policy is kept up to date and available.

Action for next year: None

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Continue recruitment efforts

Comments: We continue to recruit both SAS and consultant appraisers and engage the departments to recruit internally when one of their team steps down or retires.

Action for next year: Continue recruitment efforts

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: None

Comments: Yes, appraisers are recruitment and managed by the Trust Appraisal Leads. The Appraisal Leads are required to review performance of appraisers, including doctor's feedback, timeliness of completion of appraisal, quality of inputs, quality of outputs and compliance to policy.

The appraisal leads are required to review appraisals, monitor quality, and take appropriate remediation steps if necessary.

The appraiser role is recognised within the job plans and attracts a tariff.

Appraisal feedback from the appraisee is collected after appraisal and is sent out to appraisers at the end of the appraisal year.

Appraisals must carry out a minimum of 6 appraisals annually.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Appraisers must attend quarterly appraiser support groups (private group meetings where appraisal issues can be discussed amongst appraisers and knowledge shared).

New appraisers must attend facilitated training prior to carrying out an appraisal (this has moved to online training).

Action for next year: None

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None

Comments: Yes, appraisal compliance is reported monthly and reviewed annually by Workforce Board. Any concerns highlighted by the monthly audit will be managed by the Workforce Board through an extraordinary report.

Action for next year: None

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	372
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	365
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	7
Total number of agreed exceptions	2

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None Comments: Yes Action for next year: None

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None Comments: Recommendations are discussed with the doctor by the RO before being submitted. A letter is also sent to the doctor with the decision should this be of non-engagement or deferral. Action for next year: None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None Comments: Yes, the Head of Risk and Clinical Governance oversees the numerous processes which ensure effective governance across the organisation. The Trust governance structure provides an escalation route for areas of concern to be managed and highlighted to the Board. Action for next year: None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None Comments: Yes, individual doctors are required to provide, discuss, and reflect on an involvement in complaints, compliments, or serious incidents. The doctor is required to provide: - Written evidence from the Patient Experience department and Risk Management detailing all events listed on the Radar system where the individual is named in the past 12 months - A reference from their Clinical Director indicating involvement in complaints, compliments, and serious incidents - A letter from any other external body where the individual practices detailing involvement in any complaints, compliments, or SIs. Action for next year: None

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None Comments: Yes Action for next year: None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: None Comments: Yes Action for next year: None

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: None Comments: Yes, in order to maintain the confidentiality of such data, any request for appraisal and revalidation information for a doctor must come from the new Responsible Officer of their office. This request must be received on an MPIT or similar form and will be handled by the Medical Director's Office and approved for sending by the RO. Action for next year: None

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None Comments: Yes Action for next year: None

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None Comments: Yes, the recommended employment checks are already carried out by the Medical Staffing team and where specific information is required in respect to appraisal information, this is collected by the Medical Director's Office. Where the checks are carried out by a third party, i.e., Locum Agency, reliance is placed on the framework agreements / contracts that these checks are done by the agency. Action for next year: None

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

All actions from last year have been completed.

The Trust continues to ensure that, as a designated body, it is complying with the regulations. The development and support offered to our doctors is of great importance.

Overall conclusion:

We continue to support doctors with their appraisal & revalidation and review all doctor's wellbeing. Doctors that provide a low score or ask for extra support on their appraisal portfolio are escalated to the RO.

Section 7 – Statement of Compliance:

The Board of Milton Keynes University Hospital NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ Milton Keynes University Hospital NHS Foundation Trust _

Name: _Joe Harrison__ Signed: [signature]

Role: _CEO_______

Date: 10/07/2023_

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Meeting Title	Trust Board of Directors	**Date: 07 September 2023**
Report Title	Emergency Preparedness Resilience and Response (EPRR) Annual Assurance Review 2023	**Agenda Item Number: 14**
Lead Director	Emma Livesley, Director of Operations	
Report Author	Emma Livesley, Director of Operations	

Introduction	Statutory/Assurance Report		
Key Messages to Note	This report covers Emergency Preparedness, Resilience and Response (EPRR) annual review for 2023 and summary of Core Standards Self-Assessment for MKUH.		
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	N/A
Next Steps	N/A
Appendices/Attachments	EPRR Annual Assurance Review 2023

Emergency Preparedness Resilience and Response (EPRR)

Annual Assurance Review 2023

1.0 Background

This report covers Emergency Preparedness, Resilience and Response (EPRR) annual review for 2023 and summary of Core Standards Self-Assessment for MKUH.

2.0 NHS England Core Standards 2023 Compliance

2.1 Background

First published in January 2013, the NHS England Core Standards are the minimum EPRR standards which NHS organisations and providers of NHS funded care must meet. Core standards are assured by completion of self-assessments which enable NHS England to assess the preparedness of NHS organisations across a range of assurance indicators. The full list of compliance questions and answers can be found in the embedded document held in Appendix B.

2.2 2023 Requirements

For 2023 the self-assessment process for NHSE East of England is illustrated in table below with regional letter inserted for reference (Appendix C).

Ref	Process	Responsible	Timeline
1	NHS Trusts and providers of NHS Funded Care, must undertake a self-assessment against the 2023 NHS England EPRR Core Standards relevant to your own organisation	Trusts and Providers of NHS Funded Care Organisation	24th May 2023
2	ICB EPRR Leads and NHS England EPRR Team to meet via M/S Teams to discuss and review the assurance process and approach	NHS England Regional EPRR Team	W/C 29th May 2023
3	NHS Trusts and providers of NHS Funded Care are to ensure that their core	Trusts and Providers of NHS Funded Care Organisation	24th August 2023

	standards audit and associated documentation is completed, signed off and returned (email) to their ICB EPRR Lead.		
4*	Oversee confirm and challenge & peer review sessions with provider organisations[1]_[2]	ICB EPRR Lead	1st September – 30th September 2023
5	Oversee confirm and challenge sessions with ICB (to include the ICB and wider system provider assurance)	NHS England EPRR Team	W/C 2nd October 2023
6	LHRP Executive Group to have reviewed, scrutinised and endorse compliance levels for each NHS funded organisation	NHS England EPRR Team	31st October 2023
7 **8**	ICBs to submit an EPRR System assurance summary to the NHS England EPRR Team by email. East of England Commissioner and provider assurance ratings to be submitted to the National NHS England EPRR Team	ICB AEO and EPRR Leads NHS England EPRR Team	1st November 2023 29th December 2023

BLMK ICB to arrange point 4 date with MKUH.

2.3 Deep Dive Requirements

Each year the Core Standards review specific areas of EPRR through a 'Deep Dive' process where evidence is required and presented as part of the Core Standard return. This process **does not** contribute to the overall score, with 2023 'Deep Dive' theme covering 'EPRR Responder Training' arrangements.

2.4 Evidence Requested

This year NHS EoE has requested as a minimum the following plans as part of evidence submitted to the ICB to ensure that the correct governance processes have taken place, that the plans are fit for purpose and that they are aligned to the requirements laid out in the self-assessment:

- Trust / Provider Business Continuity Plan;

- Trust / Provider Incident Response Plan;
- Trust / Provider Incident Coordination Centre Plan;

In addition, this year's deep dive questions focus on training; therefore, further assurance of the following training information should also be undertaken to ensure that the documentation is current, appropriate and that the training needs of the on-call staff within organisations are met, this is to include evidence of:

- Training Needs Analysis;
- Training Records;
- Learning from Training

All above evidence is in place for the final submission.

3.0 MKUH Assurance Rating

NHE England national letter outlines assurance rating for Core Standards as follows:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

MKUH has RAG rated its 2023 EPRR Core Standards Self-Assessment and this is shown in tabular form below:

RAG Rating	EPRR Core Standards	Deep Dive 'Evac'	Total
Non-compliant	0	0	0
Partially compliant	1	3	4
Fully compliant	61	7	68
Total Questions	62	10	72

The Self-Assessment shows 97% compliance with core standard questions resulting in the Trust being **Substantial Compliance Level**.

To ensure MKUH moves from ‘Substantial’ to ‘Fully Compliant’ prior to 2024 Core Standards submission an action plan has been developed, outlining the outstanding areas in Appendix A, including ‘Deep Dive’ summarised below.

4.0 EPRR Work Plan 2023

The following outlines this year’s work developed under EPRR programme to ensure statutory obligations set under Civil Contingencies Act 2004, EPRR Framework and other national guidance are met.

4.1 Revised EPRR Plans for 2023

- **Evacuation and Shelter Policy** updated following revised national guidance published in 2022.
- **EPRR Policy** to align Trust commitment in EPRR programme development against revised national EPRR framework 2022.
- **Adverse Weather and Health Policy** to amalgamate previous Trust Heatwave and Cold Weather planning arrangements as part of the new national AWH plan 2023.
- **Emergency Bleep SOP** has been revised as part of annual review.
- **Mass Casualty SOP** has been revised following Blood Transfusion team forwarded revision.
- **Business Continuity Plans** annual review of all divisions and services with expectation to finalise all plans before end of 2023. EPO has further supported IT and Estates on numerous of projects requiring contingency arrangements for the hospital site.
- **Climate Change Adaptation Risk Register** has been developed to support the Trust Green Plan in carrying out a vulnerability and assessment process to climate change in line with national guidance.

All new plans will form part of the EPRR training and exercise programme to ensure staff roles outlined within are tested and embedded. All plans are accessible to all staff on the EPRR Intranet page and Trust Documentation Site with communication cascade to notify all staff of revised plans when required. Hard copies are held within all Incident Coordination Centres (ICC).

4.2 EPRR Incidents of Note

Incident	Dates	Level of Response
Emergency Bleep Loss	15.01.23, 25.01.23	Business Continuity Response
Bomb Threat Hoax*	01.02.23	Business Continuity Response
Intermittent IT Loss	14.05.23	Business Continuity Response
Industrial Action (Unions and BMA)	BMA Ongoing	Business Continuity Response

*Structured debriefs were held with a post incident report to be developed and agreed with executive team outlining a number of recommendations

4.3 Training and Exercising

Below outlines the training and exercises delivered since the last annual report. All records are held with EPO in accordance with national guidance on record management for EPRR except for exercise organised by external partners.

Name of Course / Exercise	Organiser	Date	Comment / Type of Exercise
Operation Sparrow	BLRF	21.09.22	Tabletop Ex
Exercise Perfect Storm	MKUH	30.09.22	Tabletop Ex
Vulnerable Puffin Exercise	BLRF	20.09.22	Tabletop Ex
Exercise Fox	NHS EoE	09.11.22	Command Ex
SMART Evacuation Training	TSG	Nov 22-March 23	Training
Arctic Willow	BLMK ICB	08.12.22	Tabletop Ex
Major Incident On Call Training	MKUH	12.01.23	Training
ED Major Incident incl. PRPS	MKUH	30.01.23	Training
Major Incident On-Call Training	MKUH	08.01.23	Training
ED Major Incident incl. PRPS	MKUH	05.05.23	Training
Exercise Flamingo Silk (Comms Cascade)	National	25.05.23	Comms Ex
ED Major Incident incl. PRPS	MKUH	26.05.23	Training
Major Incident On-Call Training	MKUH	12.06.23	Training

Switchboard Major Incident Training	MKUH	28.06.23	Training
ED Major Incident incl. PRPS*	MKUH	21.07.23	Training
Exercise Move	MKUH	31.07.23	Tabletop Ex
ED Major Incident Training (Consultant led)	MKUH	09.08.23	Tabletop Ex
Exercise Jigsaw (Comms Test)	MKUH	18.08.23	Comms Ex
Legal Awareness Training	MKUH	25.09.23	Training
Exercise Exodus	BLMK ICB	03.10.23	Live Ex
Exercise Blue Nimbus	TV LRF	04.10.23	Live Ex
Surviving Public Inquiry Training	MKUH	06.10.23	Training
CBRN On Call training	MKUH	24.10.23	Training
Mass Casualty On Call Training	MKUH	21.11.23	Training

*Stood down due to Industrial Action

5.0 Next Steps

- For the Executive Team to receive the report and to confirm they are assured of the Trusts compliance against statutory and national Core Standards for Emergency Preparedness, Resilience and Response

- For this report to be placed on the public board agenda for final approval

Appendix A: MKUH Core Standards and Deep Dive Action Plan

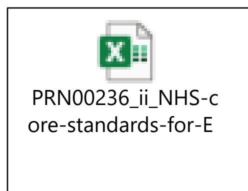
Core Standards Ref	Question	Evidence Required	MKUH Answer	Self-Assessment	Action
47	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation.	Not all services have revised BCPs for 2023 BCMS annual cycle of review		EPO to maintain support of BC leads within services to ensure all plans are up to date be end of 2023

		• Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices			

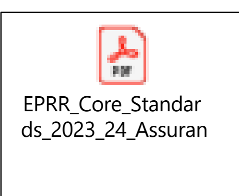
Deep Dive	Question	Evidence Required	MKUH Answer	Self-Assessment	Action
DD2	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios	ICB Contacted with following reply by EoE: The Principles of Health Command Course is delivered by the Regional Team on behalf of NHSE. It is being rolled out to Trusts following prioritisation of the ICB. If all strategic leads are booked on prior to Core Standards submission, this standard can be marked as fully compliant. If you could pass the names and email addresses to Elaine Baugh, she'll support you in getting them booked.		Awaiting on formal email from EoE
DD3	The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and	Training needs analysis roles includes EPRR staff	ICB Contacted with following reply by EoE: There isn't currently a suite or compendium of EPRR training by either UKHSA or NHSE, however if any training in your TNA for EPOs is linked to the NHS Minimum		Awaiting on formal email from EoE covering suite of training

	incident communication)		Occupational Standards and supports the EPO being competent and trained to a satisfactory level. The Regional team are currently working on a suite of training to support but that's not likely to be for this year.		
DD5	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	ICB Contacted with following reply by EoE: As above re Principles of Health Command. There's no indication from UKHSA that there are any emails on the horizon but it'll be fed to UKHSA that that'd be supportive.		As outlined in DD2 and DD3

Appendix B: Core Standards MKUH Self-Assessment



Appendix C: NHS East of England Core Standards Letter



Meeting Title	Trust Board	Date: 7th September 2023
Report Title	Risk Register Report	Agenda Item Number: 15
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 August 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

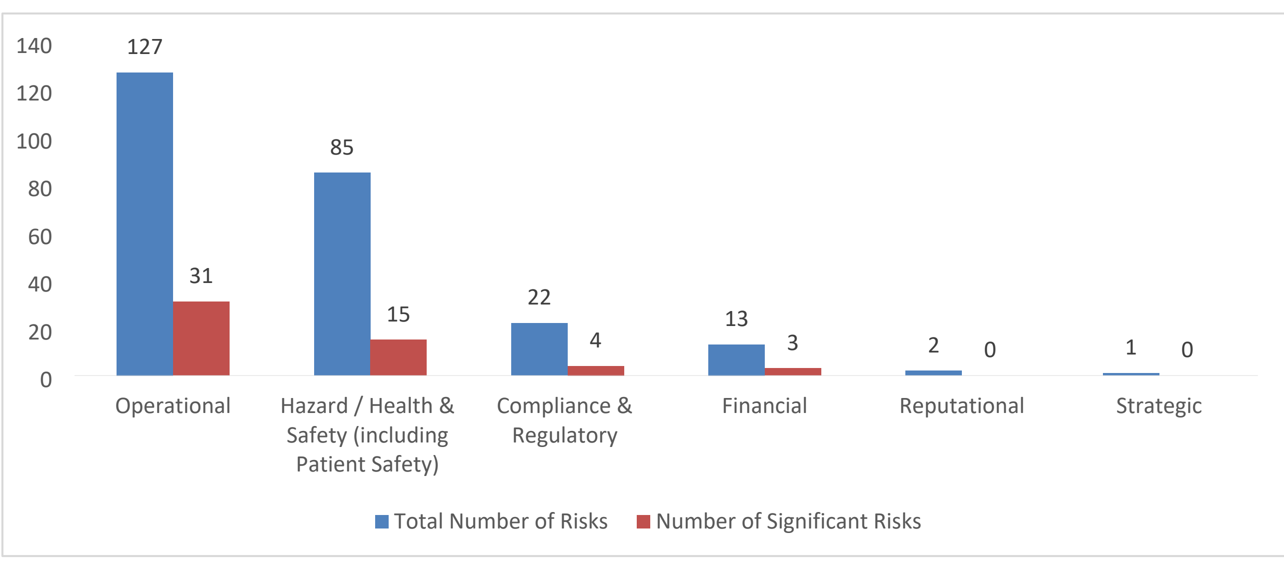
Risk Report

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

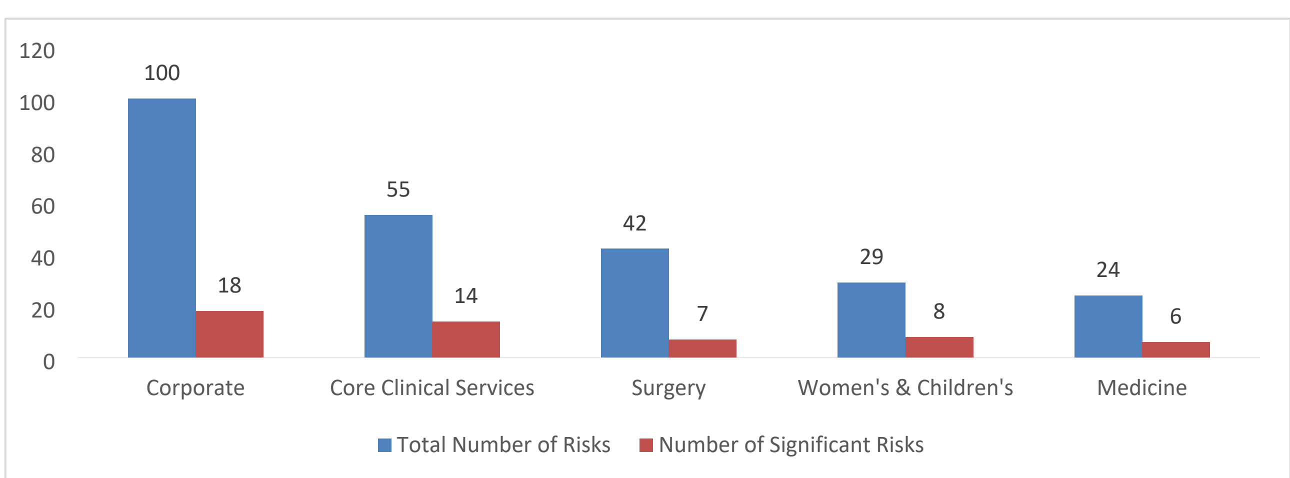
2.1 Risks by Risk Category



Note: The Risk Categories are aligned with the Institute of Risk Management Standards, with the addition of Reputational and Compliance & Regulatory.

The above chart shows that the majority of risks identified and added to the Risk Register are in relation to Operations and Hazards (Safety). These two categories make up 212 (97%) of the 250 risks, and 46 (87%) of 53 of the Significant Risks (graded 15 or above).

2.2 Risks by Division



The above chart shows that the majority of risks identified relate to Corporate Departments, such as Finance, Workforce, Estates etc. These departments represent 40% of the risks on the Risk Register. It should be noted, however, that the Divisions represent 35 66% of the Significant risks.

2.3 Risk Heatmaps

Current Score Heatmap

Likelihood	Consequence				
	1	2	3	4	5
5		3	17	10	
4		8	36	16	5
3		12	43	25	5
2	1	12	18	19	5
1		1	1	9	4

The above chart shows all 250 risks and how they are distributed in relation to their Current Risk Score. This demonstrates that 53 (21%) risks are currently graded as significant (red) risks, 139 (56%) are currently graded as moderate (amber) risk and 58 (23%) risks are currently graded as low/very low (green) risk.

Target Score Heatmap

Likelihood	Consequence				
	1	2	3	4	5
5				2	
4	2	1	4		
3	8	33	21	2	
2	4	32	43	23	6
1	1	3	21	34	8

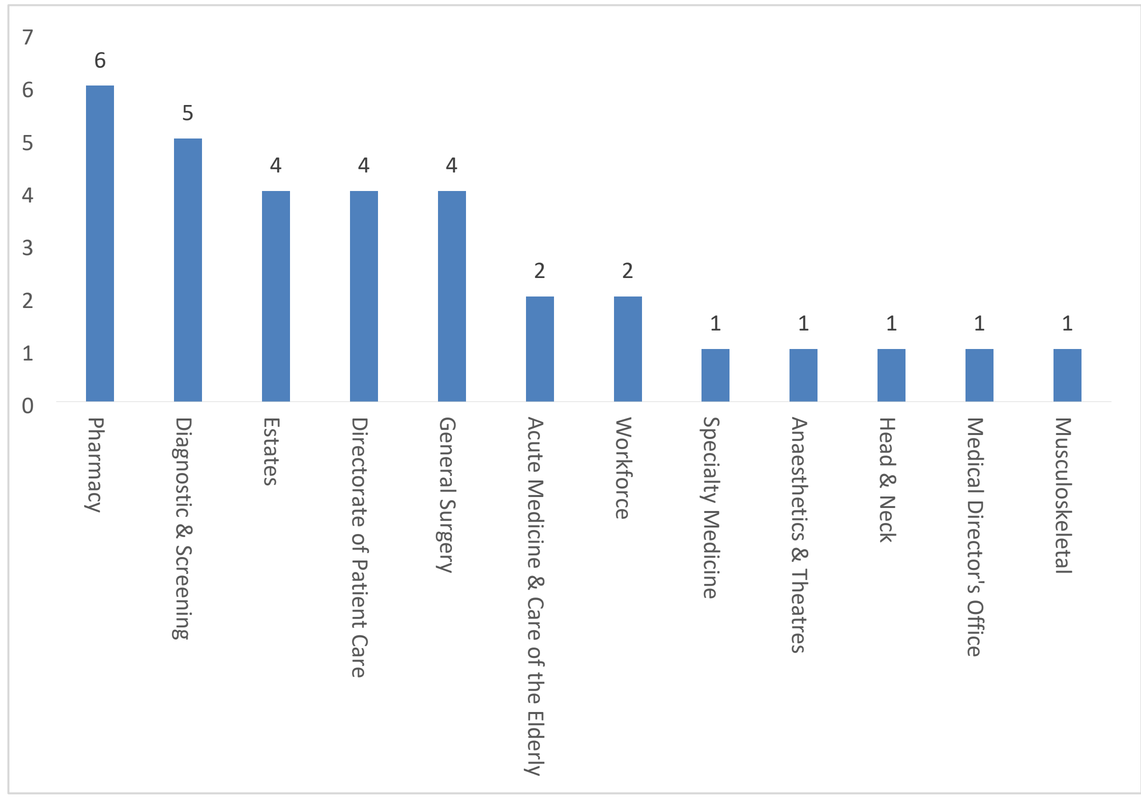
The above chart shows all 250 risks and how they are distributed in relation to their Target Risk Score. There are 2 (1%) risks where the Target Risk Score is significant. The two risks where the target is significant would both be categorised as being a 'Hazard' risk (i.e. risk of harm to patient/staff/service user) therefore, the Target Risk Score will need to be reviewed for these as they do not align with the Trust's risk appetite (see page 1 of this report). There are 57 (23%) risks that have a moderate Target Risk Score – these will be reviewed to ensure that the Target Risk Score aligns with the Trust's risk appetite. The remaining 191 (77%) have a low/very low Target Risk Score.

It should be noted that there has been little change in the heatmaps since the last report.

3. OVERDUE RISKS

At the time of reporting, there were a total of 32 risks out of 250 risks (13%) overdue their review date.

3.1 Total Overdue Risks by CSU/Corporate Department



3.2 Risks Overdue Review > 1 month = 9. This is an increase of 3 since the last report.

4. NEW RISKS = 3

RSK-472	**Estates:** Anthony Marsh
IF staff and service users (Trustwide) are subject to violence and unacceptable behaviour THEN staff/services users may sustain physical/psychological injury.	
Consequence: 5 Likelihood: 4	**Current Risk Score: 20**

RSK-473	**Patient Access:** Stevie Jones
IF the Trust does not have a working CTG flatbed scanner THEN CTGs may not being available on EDM negatively impacting on patient care, the ability to review / audit / investigate / birth reflections	
Consequence: 4 Likelihood: 5	**Current Risk Score: 20**

RSK-474	**HSDU:** Lisa Charles
IF the scopes used at White house park regularly exceed the 3hr reprocessing time THEN the JAG accreditation for both MKUH and White house endoscopy units will be at risk. Documented traceability evidence will be sought by the JAG assessors, and it will be apparent if this is the case. LEADING TO a need to carry out additional testing on scopes in both units which could lead to scopes being taken out of use whilst being tested, which will reduce throughput across both sites. If scopes are found to be insufficiently decontaminated, then the service may need to be suspended until the issue can be resolved.	
Consequence: 3 Likelihood: 4	**Current Risk Score: 12**

5. CLOSED RISKS

RSK-161	**Therapies:** Jamie Stamp
IF COVID-19 is transmitted between colleagues and patients, and between staff members THEN staff will have to self-isolate	
Consequence: 2 Likelihood: 3	**Current Risk Score: 6**
Reason for Closure:	Continue to experience low numbers of staff with Covid and therefore no impact on staffing. Mitigation remains in place as identified in previous updates and in the risk assessment. To close risk.

RSK-330	**Pathology:** Jessica Dixon
IF the Point of Care Testing team remain in their current space THEN the staffing are at significant risk of transmitting covid	
Consequence: 4 Likelihood: 3	**Current Risk Score: 12**
Reason for Closure:	Offices have now been moved. Risk can close.

6. CHANGING RISKS

Risks that have increased: 0

Risks that have decreased: 7

RSK-008	Lack of system to record mortality / morbidity data.	Current Risk reduced from 8 to 2
RSK-158	Impact of escalation beds on Therapies.	Current Risk reduced from 20 to 15
RSK-159	Capacity / Demand issues in Therapies.	Current Risk reduced from 20 to 15
RSK-214	Insufficient nursing staff (Trustwide)	Current Risk reduced from 9 to 8
RSK-258	Switchboard resources cannot manage activity	Current Risk reduced from 9 to 6
RSK-272	Maintenance of passenger lifts	Current Risk reduced from 9 to 6
RSK-423	Availability of specific enteral feeds / supply issues.	Current Risk reduced from 12 to 8

7. RISKS FOR ESCALATION TO CORPORATE RISK REGISTER

RSK-472	**Estates**
IF staff and service users (Trustwide) are subject to violence and unacceptable behaviour THEN staff/services users may sustain physical/psychological injury.	
Consequence: 5 Likelihood: 4	**Current Risk Score: 20**
Reason for Escalation:	This is a Trustwide risk, not specific to the Estates Team. The risk requires a multidisciplinary approach. Therefore, this risk should be escalated onto the Trust Risk Register.

8. RECOMMENDATION

The Committee is asked to review and discuss this paper.

The board is asked to approve the escalated risk (see section 7) onto the Corporate Risk Register.

9. 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.

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-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	Julie Orr	13-Jul-2023	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 and Children's Boards(24-Nov-2021), MKHFT has named leads for Safeguarding Adults and Children Dr	Low	Tolerate	Risk owner updated to Julie Orr	24-Nov-2021
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	Julie Orr	13-Jul-2023	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	Risk owner updated to Julie Orr	24-Nov-2021
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	Overdue	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-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	Overdue	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

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-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	Overdue	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), Audit and Risk assessments for outlying buildings planned 2022(30-Nov-2021), Ben Hazell is trained and appointed Appointed Person (AP)(22-Mar-	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	Overdue	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
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	Overdue	12	12	9	Luing Cowley Lift awaiting upgrades, difficult as no alternative when lift not in service. (14-Nov-2022) (29-Aug-2023)	There is an SLA is place that states that the lift will be repaired within 4 hours, normally 1-2hours(30-Nov-2021), ResQmat are on the landings on floors 3 & 4 and should be used in the event disabled persons and those with limited mobility, are unable to leave their respective floors, although staff are not trained in their use(30-Nov-2021), Call bell/telephone in lift to call for assistance(30-Nov-2021), Monthly lift inspections in place(30-Nov-2021), 6 Monthly PPM in place(30-Nov-2021), Annual insurance inspections in place(30-Nov-2021), ResQmat training video in place created by Manual Handling adviser(30-Nov-2021), Refurbishment of ward 14 lift carried out(30-Nov-2021), On the Capital Programme(30-Nov-2021), Outpatients Business Case approved for M&E study, with any identified anticipated to be completed end of FY 2022(30-Nov-2021), 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-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	Overdue	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

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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	24-Jul-2023	25-Aug-2023	Overdue	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	no additional risks identified	16-Mar-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	27-Jul-2023	27-Aug-2023	Overdue	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	reviewed at pharmacy CIG no changes	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	27-Jul-2023	27-Aug-2023	Overdue	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	reviewed at pharmacy CIG no changes	01-Oct-2021
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	Pending	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
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	01-Aug-2023	31-Aug-2023	Pending	16	15	6	agency physiotherapist and occupational therapist to cover additional workload. (24-Aug-2023), 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)	Medium	Treat	Since previous risk review ward 2b has been closed as an escalation ward. Staff from OT practice who were supporting this ward have been moved to T&O, Surgery and Frailty. Physio locum has started to support escalation areas. Recruitment of substantive workforce is ongoing. Currently have 13.7 WTE vacancies without cover across inpatient therapies.	27-Nov-2018

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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	Pending	16	9	3	International Recruitment of 100 Nurses in 2023 (31-Oct-2022), Shared recruitment campaigns for HCSW (19-Jul-2023), Recruitment plans by role (19-Jul-2023), Recruitment Specialists (19-Jul-2023)	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-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	Pending	15	4	4	Review of the Nurse Apprenticeship pathway is underway with newly appointed Head of Practice Education (19-Jul-2023), Creation of Apprenticeship Strategy (08-Jun-2023), Increase available apprenticeships (19-Jul-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-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	26-Jul-2023	31-Aug-2023	Pending	12	9	6	Training in the use of medical equipment (26-Jul-2023), Auditing PPMs (26-Jul-2023), Medical Devices Management policy- following processes (26-Jul-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	26-Jul-2023	31-Aug-2023	Pending	12	9	6	Medical Devices Group meetings are held monthly to discuss procurement (26-Jul-2023)		Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
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	26-Jul-2023	31-Aug-2023	Pending	25	15	10	Medicine Division to carry out a risk assessment and build it in their contingency plan (29-Jun-2023), Women's & Children's Division to carry out a risk assessment and build it in their contingency plan (29-Jun-2023), Core Clinical Services Division to carry out a risk assessment and build it in their contingency plan (29-Jun-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), Surgery Division to carry out a risk assessment and build it in their contingency plan(09-Dec-2022)	Low	Treat	Risk approved onto the Corporate Risk Register at RCB	11-Nov-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	09-Jul-2023	01-Sep-2023	Pending	15	8	4		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	Wards establishment much improved with minimal vacancies however escalation areas remain open.	24-Nov-2021

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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	31-Jul-2023	01-Sep-2023	Pending	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-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	02-Aug-2023	04-Sep-2023	Pending	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	Paediatric team fully staffed, however reduction in bank hours (therefore reduced OP clinics) will impact waiting times due to number of referrals vs capacity. Considering other ways to provide some of the service.	01-Oct-2021
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	02-Aug-2023	04-Sep-2023	Pending	12	8	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	National situation with feed supplies slightly improved, reduced risk and monitor for next month	24-Jan-2023
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, documentation, audits, risks and other risk/governance related activity.	LEADING TO an inability for the Trust to defend itself against future claims/litigation leading to potential financial penalties, improvement notices, PFD notices from HM Coroner, adverse publicity etc., an inability to evidence compliance with CQC regulations and freedom of information requests, and potential for an increase in incidents, complaints and claims due to lack of learning from incidents.	Organisation	Paul Ewers	09-Aug-2023	08-Sep-2023	Planned	20	9	6	Redesign of Analytics to meet the needs of the Trust (04-Aug-2023), System redesign to meet the needs of the new Patient Safety Incident Response Framework (PSIRF), Training and Comms in relation to Documentation Process (including, how to access the latest versions)	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 updated to reflect Documentation and Audit requirements	28-Apr-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	14-Aug-2023	08-Sep-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-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	14-Aug-2023	08-Sep-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

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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	14-Aug-2023	08-Sep-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-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	14-Aug-2023	08-Sep-2023	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	14-Aug-2023	08-Sep-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-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	14-Aug-2023	08-Sep-2023	Planned	16	12	9		Weekly vacancy control panel review agency requests(23-Nov-2021), Control of staffing costs identified as a key transformation work stream(23-Nov-2021), Capacity planning(23-Nov-2021), Robust rostering and leave planning(23-Nov-2021), Escalation policy in place to sign-off breach of agency rates(23-Nov-2021), Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used(23-Nov-2021), Agency cap breaches are reported to Divisions and the FIC(23-Nov-2021), Divisional understanding of how to reduce spend on temporary staffing to be developed(23-Nov-2021), Agency review bu Executive Directors(10-Jul-2023)	Medium	Tolerate	Additional controls are in place for long lines of agency that require an Exec sign off	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	14-Aug-2023	08-Sep-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	14-Aug-2023	08-Sep-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
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	14-Aug-2023	08-Sep-2023	Planned	16	20	9	Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24. (29-Aug-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	On-going conversations with regional and national capital team	01-Apr-2022

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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-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	Kirsty McKenzie-Martin	11-Aug-2023	11-Sep-2023	Planned	9	8	2	Mental Health pathway to be reviewed by the Corporate Team (23-Nov-2022)	Patients assessed and those at risk of self harming are placed in an area they can easily be observed.(22-Sep-2021), New mental health room has been ligature and risk assessed by CNWL team(22-Sep-2021), Remind all staff about keeping swipe doors closed so they don't access rooms where they are not observeble Last ligature audit was April 2019 and actioned.(22-Sep-2021), Risk Assessment of adult and C&YP areas reviewed April 2019(22-Sep-2021), Check list in place to risk asses each Adults and C&YP attending with MH/DSH issues to identify personalised action plan(22-Sep-2021), Follow up ligature RA completed as advised by H&S lead for trust Risk Assesment completed - identified need for collapsible clothes hangers in public toilets - request to estates to install and completed; x1 non-compliant cord pull also in toilet - changed(22-Sep-2021), Repeat Ligature Risk Assessment for 2020 required(22-Sep-2021), ensure all staff are aware of the new Policy - "Ligature Risk Awareness"(22-Sep-2021), E-Care Risk Assessment Tool to be reviewed/adapted(10-Aug-2022)	Low	Treat	discussed with 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-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	11-Aug-2023	12-Sep-2023	Pending	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. (09-Aug-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-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	21-Aug-2023	22-Sep-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 move this forward, business case still to be written	01-Nov-2021

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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-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	David Baker	28-Jul-2023	28-Sep-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. (27-Jul-2023), Mechanical Engineer is being trained as AP, and currently being assessed ready for official appointment. (30-May-2023), Appointed AP(D) (27-Jul-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	Risk reduced now David Baker has been signed off as AP(D). still no AP(D) for Endoscopy and only an AE(D) visit twice annually.	25-Aug-2021
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(10-Feb-2023), Purchasing iPad to enable photos(10-Feb-2023)	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
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	24-Aug-2023	29-Sep-2023	Planned	20	15	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	ward 2b has closed and OT practice staff have been re-allocated to support other wards, Vacancies remain high at 17 WTE but 10 of these have been appointed to.	04-Mar-2019

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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	24-Aug-2023	29-Sep-2023	Planned	15	15	6	Recruitment of vacant posts (24-Aug-2023), Pathway review (24-Aug-2023)	Recruitment(01-Dec-2022)	Low	Treat	OT Lead post has now started, but B6 OT is on long term sick now. x1 B5 PT post covered by locum and other B5 PT post has been appointed to with a start date of the 29th August. x2 resignations received from this team with first leaving on 13th September and other at the end of November.	01-Dec-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	06-Jul-2023	30-Sep-2023	Planned	20	16	12	Staff competence and confidence with Radar reporting, with improved reporting rate, reduction in inaccurate reports on system and/or failure of incidents being reported (24-Oct-2022)	Incident Reporting Policy(06-Sep-2021), Incident Reporting Mandatory/Induction Training(06-Sep-2021), Incident Reporting Training Guide and adhoc training as required. Radar to provide on site & bespoke training IT drop in hub to be set up 2 days a week for staff drop ins(06-Sep-2021), Datix Incident Investigation Training sessions(06-Sep-2021), Daily review of incidents by Risk Management Team to identify potential Serious Incidents and appropriate escalation(06-Sep-2021), Serious Incident Review Group (SIRG) ensure quality of Serious Incident Investigations(06-Sep-2021), SIRG ensure appropriate reporting of Serious Incidents to Commissioners(06-Sep-2021), Standard Operating Procedure re Risk & Governance Team supporting the closure of incident investigations during unprecedented demand on service(06-Sep-2021), Implementation of new Risk Management Software to make incidents easier to report and improve engagement with staff(06-Sep-2021)	Low	Treat	Risk reporting rate showing an increase however still concerns that some clinical incidents are not being reported Single Radar reporting form now in place	06-Sep-2021
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	06-Jul-2023	30-Sep-2023	Planned	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	Risk reviewed & assurances not robust enough Gaps in audit evidence remain Awaiting Radar audit module	06-Sep-2021
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	06-Jul-2023	30-Sep-2023	Planned	25	12	4	Implementation of Radar Documentation Module (03-Aug-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	Completion of Radar document module due August 2023 Audit module pending Ongoing interim glitches with system error + awaiting final completion of analytics Data assurance concerns remain due to difficulties pulling data (impacted by system/form changes)	06-Sep-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	06-Jul-2023	30-Sep-2023	Planned	12	6	3		Trust Documentation Policy(06-Sep-2021), Library resource to source current references(06-Sep-2021), Governance Leads provide support to staff reviewing guidelines and policies(06-Sep-2021), Monthly trust documentation report shared with Governance Leads(06-Sep-2021), New process via Trust Documentation Committee for 'removal' of significantly breached documents(06-Sep-2021), Work plan in place to check approval of documents/links to national leaflets(06-Sep-2021), Implementation of Radar Document Management System to improve engagement and access to the documentation process(06-Sep-2021)	Low	Treat	Radar document module due for full Trust implementation August 2023 Number of breached documents remains high (majority corporate areas)	06-Sep-2021

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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	06-Jul-2023	30-Sep-2023	Planned	15	10	5		Fire Warden advised to work within current knowledge and skill gained through mandatory fire training(06-Sep-2021), No team member to attempt to fight fires with equipment untrained to use(06-Sep-2021), Risk assessment shared with team / Staff awareness(06-Sep-2021), Quarterly fire safety audits completed(06-Sep-2021), Good housekeeping practicalities - reiterated at team huddle(06-Sep-2021), Fire safety signage displayed -action cards and assembly points identified, clearly visible to team members and others visiting corridor(06-Sep-2021), Fire alarm system checked regularly in line with Trust policy and is audible in corridor(06-Sep-2021), Team members have undertaken and are up to date with mandatory training (compliance checked monthly)(06-Sep-2021), Team risk assessment for lone working on back of Covid changes which covers fire(06-Sep-2021), Risk & Clinical Governance Team Fire Warden to attend Fire Warden Training(06-Sep-2021), There was a suggestion that posters were put up for staff to follow when Kevin is not in.(21-Dec-2021), There was a recommendation that in light of the working from home arrangements, it might be appropriate for everyone to have the training so that there is adequate cover.(21-Dec-2021)	Low	Treat	Previous fire warden now not longer part of the team although when on site still based in Oak House Question posed re how fire warden nominated officers works for Oak House given flexible working & on site workers different each day. Advised sufficient number required but no further clarity	06-Sep-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	24-Jul-2023	30-Sep-2023	Planned	15	5	5		All NPSA recommendations were acted upon in 2011 in the Trust as per NPSA requirements by the ANP for Nutrition(24-Nov-2021), Nutrition Committee overseeing this alert and is standard item on agenda from Dec 16. Clinical Medical and Nutritional ANP leading on the action plan(24-Nov-2021), Policies, protocols and bedside documentation reviewed to ensure compliance(24-Nov-2021), Ongoing programme of audit. Previous audit data presented to NMB Spring 2016(24-Nov-2021), Dietetic Amalga database identifies patients who require Nasogastric feeding(24-Nov-2021), Trust declared compliance with 2016 Nasogastric Tube Misplacement: Continuing Risk of Death or Severe Harm Patient Safety Alert (NHS/PSA/RE/2016006)(24-Nov-2021), The NG tube used by the trust was changed in 2020 to a tube that is more radiopaque and is therefore easier to interpret on X-ray(24-Nov-2021), pH strips are purchased from one supplier to avoid confusion with colour interpretation(24-Nov-2021), Two nutrition nurses available to place NG tubes if there are no trained clinical staff available(24-Nov-2021), Radiographers trained to interpret x-rays for confirmation of NG tube tip position. This speeds up reporting and avoids junior medical staff having to assess X-rays(24-Nov-2021)	Low	Tolerate	Risk reviewed at Therapies CIG - No change to risk	23-Apr-2014
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
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

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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-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-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-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	25-Jul-2023	25-Oct-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

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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	25-Jul-2023	25-Oct-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, Order for £10K placed with Nene Valley(29-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021
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	25-Jul-2023	25-Oct-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-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	24-Aug-2023	31-Oct-2023	Planned	25	16	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021), Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(04-Nov-2021), Added to capital plan(04-Nov-2021), Feasibility study completed(04-Nov-2021)	Low	Treat	Update required for milk kitchen	19-Dec-2022

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-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	25-Jul-2023	31-Oct-2023	Planned	16	9	9	Creation of retention toolkit (20-Jul-2023), Staff Survey Action Plans for key areas of focus (20-Jul-2023), Review of Retention Frameworks in Core Clinical post-implementation (20-Jul-2023), Review of Exit Interview process, Review of local induction/onboarding process (20-Jul-2023)	Variety of Organisational Development and Reward initiatives, including Event in the Tent, P2P, Schwartz Rounds, Living our Values, Annual Staff Awards and feedback from staff being acted upon(25-Nov-2021), Monitoring via staff survey feedback and local action plan based outcomes(25-Nov-2021), Health and Wellbeing promotion, education and prevention via Staff Health and Wellbeing(25-Nov-2021), Online onboarding and exit interview process in place(25-Nov-2021), Flexible working and Agile Working policies in place(25-Nov-2021), MK Managers Way in place(25-Nov-2021), Recruitment and retention premia in place, including Golden Hello for Midwives(25-Nov-2021), Enhanced social media engagement in place and ongoing(25-Nov-2021), Annual funding initiatives to upskill staff and retain them through ongoing education e.g. Chief Nurse Fellowships, PGCE and Rotary Club Bursary fund(25-Nov-2021), Refer a Friend Scheme introduced in 2022 to improve retention and recruitment.(10-May-2022), International Recruitment ongoing to recruit 125 nurses in 2022, attraction campaign to commence in 2022 with national advertising of the Trust as employer of choice (10-May-2022)	Low	Tolerate	Risk Reviewed - Controls updated. No change to Risk Score	02-Jan-2023
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
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	21-Aug-2023	21-Nov-2023	Planned	8	15	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	Monthly Review Meeting with the contractor - Daily Issues log started - to be discussed at the monthly reviews	01-Dec-2022
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-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	09-Aug-2023	30-Nov-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. New working group, looking at all elements of this topic started early Aug 2023, with the expectation that this action may close or change as a result. To be reviewed next quarter.	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	New working group focusing on this topic will generate additional actions and progress on this risk over the next quarter. To be updated in November.	25-Jan-2023

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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	09-Aug-2023	30-Nov-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. Update Aug 2023 - being reconsidered during early stages of DQ review., Review volumes against historical figures to reflect reality of challenge. Include in business case. Consider additional posts for all.	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly(26-Nov-2021)	Low	Treat	Volume of work is increasing month on month without additional staff to support.	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	09-Aug-2023	30-Nov-2023	Planned	9	6	6	Accepted risk & continue to do as a monthly audit, with assistance identified and acted on.	eCARE training of correct process -eCARE training includes advice on only performing tasks related to professional registration and job role(26-Nov-2021), Code of conduct - NMC -eCARE pop up requires staff to state who advised them to prescribe medication & how (verbally/written)(26-Nov-2021), Monthly audit of in place a mechanism where medications prescribed by non-physicians are audited monthly against the known list of Non-Medical Prescribers/pharmacists/Midwives. Inconsistencies will be escalated to CNIO for investigation(15-Dec-2021), SOP to be produced to support monthly audit.(16-Feb-2022)	Low	Tolerate	Continues to be reported on a regular basis, for review and ad-hoc action.	25-Jan-2023
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	09-Aug-2023	30-Nov-2023	Planned	12	12	9	Drive adoption of CareAware Connect, including the support from senior Nursing Leadership.	eCARE alert if mismatch between wrist band & electronic drug chart. Correct workflow taught in eCARE training. Monthly scanning compliance report(26-Nov-2021), CareAware Connect going live by August 2023(11-Apr-2023)	Low	Treat	Risk extended while adoption of CareAware connect and support from Nursing Leadership is introduced.	25-Jan-2023
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	09-Aug-2023	30-Nov-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	Awaiting updates from supplier being able to validate a new version of the underlying operating system.	25-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	09-Aug-2023	30-Nov-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. New data standard has been released, work required on SDEC data collection before consideration for meeting national standards.		Medium	Treat	Expecting a working group to start to focus on this, for delivery by next April/July 2024.	25-Jan-2023
RSK-425	25-Jan-2023	IF the current mechanisms used for reporting on RTT status continue, along with the current use (and third-party support) of the tools to populate PTL reporting, pathways can 'drop' from the PTL due to legacy logic and rules deeply embedded in the PTL build to cleanse the PTL THEN the data available for submission will continue to require significant overhead to review, rectify and improve (i.e. veracity etc.) LEADING TO an inability to submit with short turnarounds, continued challenges in seeing patient pathways, prioritizing care etc. and potentially a risk to patient safety as a result.	Potential impact to patient care due to an inability to see patient pathways at a system level.	Organisation	Craig York	09-Aug-2023	30-Nov-2023	Planned	9	12	6	DQ Working Group Focus on RTT and PTL content will scope work required.	Business Case being submitted by late spring to implement RTT functionality.(11-Apr-2023)	Medium	Treat	Working group started early August with the objective of improving the systems and processes involved here. Updates to follow next quarter.	25-Jan-2023
RSK-226	25-Nov-2021	IF the Research Nurses have a clinic room without a couch or trolley THEN they will be unable to perform their procedures and examinations	LEADING TO safety risk to patients, decrease patients recruitment	Organisation	Antoanela Colda	24-Jul-2023	21-Dec-2023	Planned	20	12	3		Phlebotomy procedures will be undertaken in the Blood Taking Unit(25-Nov-2021), Physical assessment using consultant's clinic rooms(25-Nov-2021), Request submitted to the Space Committee for additional space(25-Nov-2021)	Low	Treat	Request submitted to Trust Space committee, waiting updates	25-Nov-2021

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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-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-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
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), road and path repairs to the ward 16 entrance	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-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-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

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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-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-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-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-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 (17-Jul-2023), Cleanse of the Patient Tracking Lists for the following services to be undertaken, utilising additional non-recurrent resource - Ophthalmology; ENT; Urology; Trauma & Orthopaedics; Gynaecology (17-Jul-2023)	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

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-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 expected to use the equipment with the patient) •Once the LVR is not longer being used with the patient we will ensure it is promptly removed from the bedspace and disposed of	Medium	Tolerate	No changes to risk score, continue to review 3 monthly. No incidents identified.	17-Jan-2020
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	29-Jun-2023	30-Jun-2024	Planned	15	6	3	Contract KPI's agreed as part of new contract (29-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-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
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	25-Jul-2023	01-Jan-2025	Planned	12	9	3	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. (27-Jul-2023)	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), An Estates Officer is to be appointed as AP(D) following training and approval.(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021

Meeting Title	Trust Board of Directors	**Date:** 07 September 2023
Report Title	Board Assurance Framework	**Agenda Item Number: 16**
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 Board is asked to review and make recommendations as appropriate. Please note the updates to the commentaries on **Risk Entries 4 and 6 (pps 16 and 21).**		
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	Trust Executive Committee, August 2023 Workforce and Development Assurance Committee, August 2023 Finance and Investment Committee, September 2023
Next Steps	Trust Executive Committee, September 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

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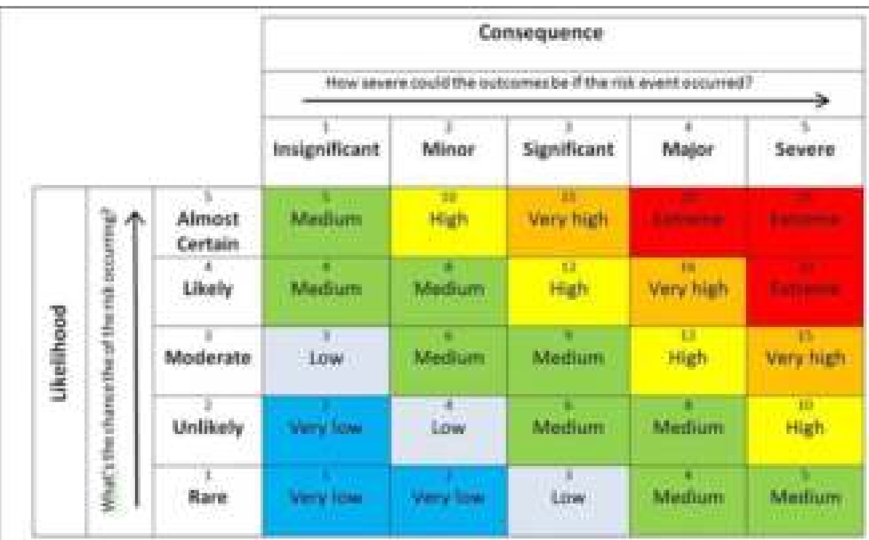
Risk treatment strategy: Terminate, treat, tolerate, transfer

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

Assurance ratings:

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

5X5 Risk Matrix:



Likelihood (What's the chance 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	Medium	High	Very high	Extreme	Extreme
4 Likely	Medium	Medium	High	Very high	Extreme
3 Moderate	Low	Medium	Medium	High	Very high
2 Unlikely	Very low	Low	Medium	Medium	High
1 Rare	Very low	Very low	Low	Medium	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.

Next Six to 12 Month Risk Profile (2023)

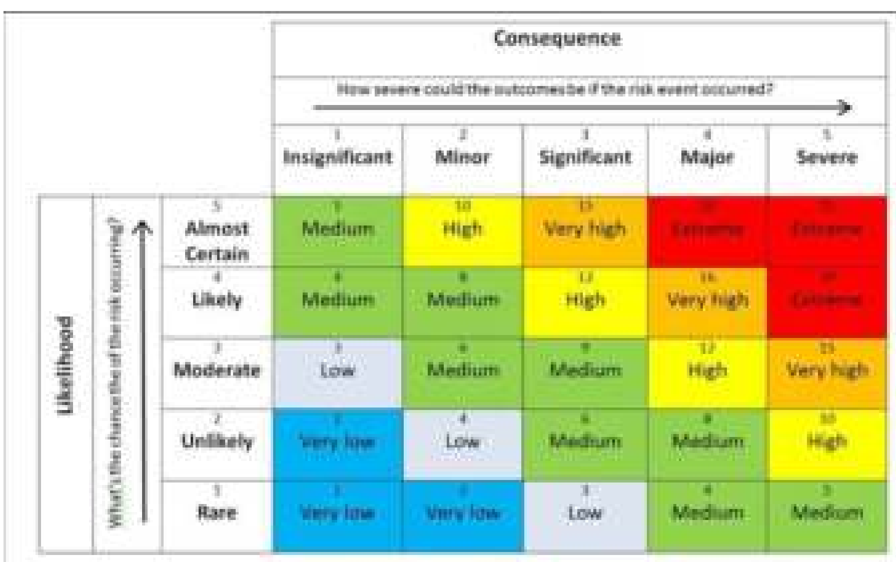
The feedback from the three Board risk seminar groups (shown below) has been distilled into five key risks against the achievement of the Trust's strategic objectives in the immediate term. These are as follows:

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



Consequence

How severe could the outcomes be if the risk event occurred?

Likelihood (What's the chance of the risk occurring?)	1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
5 Almost Certain	Medium	High	Very high	Extreme	Extreme
4 Likely	Medium	Medium	High	Very high	Extreme
3 Moderate	Low	Medium	Medium	High	Very high
2 Unlikely	Very low	Low	Medium	Medium	High
1 Rare	Very low	Very low	Low	Medium	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

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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 July August 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	02/08/2023	**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

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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

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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 capital funding to meet the needs of population we serve

Strategic Objectives

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Strategic Risk	If there is insufficient capital funding available, 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	30/08/23	**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 and has informal influence	Continued review of capital spends against available resources.	**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.	only over local ICS capital. The ICS has limited control on the allocation of operational capital from NHS England.	Close relationship 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

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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	Tracker (chart: Score and Target, Dec–Aug; axis 0, 20, 40)
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	24/08/2023	**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	30/08/23	**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, including impact of continued industrial action. 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 Meeting in Public	Date: 07 September 2023
Report Title	**Audit Committee Meeting Summary Report – 17 July 2023**	**Agenda Item Number:**
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 the 2022/23 Self Evaluation Report.

2. Items identified for escalation to Trust Board

None.

3. Summary of matters considered at the meeting

a. The Committee reviewed and noted the Audit Representation Letter.

b. The Committee reviewed and noted the External Auditor's report on the Trust's Value for Money (VfM) Arrangements.

c. The Committee reviewed the 'Updated Management Response to the 2022/23 External Audit Final Accounts Audit Findings Report' and supported the attached improvement action plan. The Committee will monitor the progress of the improvement action plan's implementation.

d. The Committee reviewed the Internal Audit Action Tracking Status Report and noted the significant improvement made in 2022/23 with regards to the implementation of Internal Audit recommendations. The Trust Secretariat will continue to work with the Internal Auditors to ensure the recommendations are implementation as required.

e. The Committee reviewed and noted the progress made with regards to the 2023/24 Counter Fraud Workplan, and the counter fraud investigations being undertaken.

f. The Committee reviewed the Board Assurance Framework, and the Corporate and Strategic Risk Registers. The Committee agreed to hold a Risk Seminar in September 2023.

4. Highlights of Board Assurance Framework Review

None

5. Risks/concerns (Current or Emerging) identified

N/A

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

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

Meeting Title	Trust Board Meeting in Public	Date: 07/09/2023
Report Title	**Finance and Investment Committee Summary Report – 06/06/2023**	**Agenda Item Number:**
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

a. The Finance and Investment Committee approved the 4-year contract with DePuy for Trauma Consumables.

b. The Finance and Investment Committee approved the design and enabling fee costs for the 3 Hospital Capacity Capital Business Cases.

c. The Finance and Investment Committee approved the Committee Self-Evaluation Report.

2. Items identified for escalation to Trust Board

a. Contract Agreement for Trauma Consumables

b. 3 Hospital Capacity Capital Business Cases.

3. Summary of matters considered at the meeting

a. The Committee reviewed and noted the Performance Report for Month 01.

b. The Committee reviewed and noted the Finance Report for Month 01.

c. The Committee reviewed and noted the Capital Programme Expenditure Update for Month 01.

d. The Committee received an update on developments around the Financial Efficiency Plan for 2023/24.

e. The Committee received and noted the Cost Pressure Management report.

4. Highlights of Board Assurance Framework Review

a. 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

a. Efficiencies around cost pressures.

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: 07/09/2023
Report Title	Finance and Investment Committee Summary Report – 04/07/2023	Agenda Item Number:
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 a. The Finance and Investment Committee approved the Radiotherapy Variation Paper for CT Scanner Business Case. b. The Finance and Investment Committee approved the National Cost Collection (NCC) Annual Costing.
2. Items identified for escalation to Trust Board a. Radiotherapy Variation Paper for CT Scanner.
3. Summary of matters considered at the meeting a. The Committee reviewed and noted the Performance Report for Month 02. b. The Committee reviewed and noted the Finance Report for Month 02. c. The Committee reviewed and noted the Capital Programme Expenditure Update for Month 02.
4. Highlights of Board Assurance Framework Review a. 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*

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Meeting Title	Trust Board Meeting In Public	**Date:** 07 September 2023
Report Title	Summary Report from the Trust Executive Committee Meeting held on 12 July 2023	**Agenda Item Number:**
Chair	Joe Harrison, Chief Executive	
Report Author	Timi Achom, Corporate Governance Officer	

Key Messages to Note

a. Matters approved by the Committee

Business cases

a. Core Clinical's Capital Scheme Reallocation Business Case.

b. The Urology Investigation Unit Business Case.

2. Matters Recommended for Trust Board approval

None

3. Summary of matters considered at the meeting

a. The Committee received and reviewed the CQC Preparedness Highlight Report.

b. The Committee received and reviewed the Corporate Risk Register and Board Assurance Framework.

c. The Committee received a Patient Safety Report which highlighted the work the recently reinstated Sepsis Working Group was beginning to undertake.

d. The Committee reviewed the Risk Management Escalation Report which focused on the steps being undertaken to support the implementation of the new Patient Safety Incident Response Framework.

e. The Committee reviewed and noted the Performance Report for Month 02.

f. The Committee reviewed and noted the Finance Report for Month 02.

g. The Committee received the Workforce Report, which stated that the Trust's staffing body totalling 4206 employees, was at the highest it had ever been. The report noted that staff absence had declined to 3.9% which indicated a low turnover.

h. The Nursing, Midwifery and Allied Health Professionals Biannual Safe Staffing Report noted that the registered nurse and midwifery vacancy rate had declined to 6.5% in June 2023 from 12.2% in December 2022.

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:** 07 September 2023
Report Title	Summary Report from the Trust Executive Committee Meeting held on 09 August 2023	**Agenda Item Number:**
Chair	John Blakesley, Deputy Chief Executive	
Report Author	Timi Achom, Corporate Governance Officer	

Key Messages to Note

a. Matters approved by the Committee

Business cases for the procurement of

a. Vital Sign Monitors and Spot BP Monitors

b. Cardiac Ultrasound Machine

c. Cardiac monitors & telemetry replacement.

2. Matters Recommended for Trust Board approval

None

3. Summary of matters considered at the meeting

a. The Committee received and reviewed the CQC Preparedness Highlight Report.

b. The Committee received and reviewed the Corporate Risk Register and Board Assurance Framework.

c. The Committee received a Patient Safety Report which highlighted the steps being taken to improve the IT connectivity of the Community Midwifery Team, while they worked in the Community.

d. The Committee reviewed the Executive Director Update on Quality Improvement which focused on the steps being undertaken to integrate quality improvement with Patient Safety as part of the Patient Safety Incident Response Framework (PSIRF).

e. The Committee reviewed and noted the Performance Report for Month 03.

f. The Committee reviewed and noted the Finance Report for Month 03.

g. The Committee received Executive Director Update on Estates and Environment which highlighted the procurement of the new electric car superchargers. The charger will be located at various locations across the hospital site and be operational from September 2023.

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: 07/09/2023
Report Title	Charitable Funds Committee	Agenda Item Number:
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

a. The Committee approved the revised Charitable Funds Policy and the new Ethical Fundraising Policy.
b. The Committee approved the Committee Evaluation Report.

2. Items identified for escalation to Trust Board

None

3. Summary of matters considered at the meeting

a. The Committee received the Charity Finance Report and noted the decline in public donations due the cost-of-living pressures.
b. The Committee reviewed the Charity Partners Report and noted that the Trust had secured substantial charitable funding for the construction of the proposed hospital helipad.
c. The Committee received a report which highlighted the Hospital Charity contributions to patient experience through the procurement of the Patient Experience Resource Trolley. The Trolley contained a wealth of information for patients and families, including information on how to share feedback, hospital and ward information, activity items for patients and visitors to use, resources to help patients and families stay in touch, and comfort items for patients to use on the wards.

4. Highlights of Board Assurance Framework Review

N/A

5. Risks/concerns (Current or Emerging) identified

a. Fundraising challenges during this time of cost-of-living pressures.
b. Delay with securing planning permission from the Northampton planning officers was impacting on the ability of David Adams to progress with his donation.
c. Artwork on corridors being damaged.
d. A new Charity Investment Strategy. Was being drafted.
e. A new Ethical fundraising policy had been drafted to manage reputational risk in relation to donors.

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*

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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	Freedom to Speak Up Guardian Report
July	Annual Claims Report
	Equality, Diversity & inclusion (ED&I) Update
	Falls Annual Report
	Pressure Ulcers Annual Report
September	
November	Green Plan Update (C/F from July 2023)

	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
	Safeguarding Annual Report
	Research & Development Annual Report
	Emergency Preparedness, Resilience and Response Annual Report
	Annual Complaints Report
	Annual Patient Experience Report
	Patient Safety Incident Response Framework, PSIRF – Policy and Plan