Bundle Trust Board Meeting in Public 2 November 2023

0.1 10:00 - Agenda
1. DRAFT Agenda Board Meeting in Public - 02.11.23 v 3

1.2 10:00 - Apologies
Chair

2 10:01 - Declarations of Interest
Chair

3 10:02 - Patient Story
Chief Nursing Officer

4 10:17 - Minutes of the Last Meeting
Chair
4. Minutes Trust Board Meeting in Public 07.09.23 AD Final

5 10:19 - Matters Arising and Action Log
Chair
5. Board Action Log 07.09.23

6 10:20 - Chair's report
Chair
6. Chair's Report Coversheet Nov 2023
6b. Chair's report

7 10:25 - Chief Executive's Report
Chief Executive
7a. External Reviews and Support - Organisational and Board Culture
7b. BLMK ICB September 2023 update
7c. The-Denny-Report_23.09.11_13.45_ac

8 10:30 - Serious Incident and Learning Report
Chief Medical Officer
8. SI report for Trust Board November 2023

9 10:35 - Mortality Update
Chief Medical Officer
9. Board Mortality Sept 2023

10 10:40 - Maternity Assurance Group Update
Chief Nursing Officer
10. MAG Trust Board Sept 2023
10b. MAG Minutes 28.09.2023_IR

11 10:45 - Safeguarding Annual Report
Chief Nursing Officer

11. Safeguarding Annual report 2022-2023 Final JO-SA

12 10:50 - Annual Complaints Report
Chief of Corporate Services
12 .Complaints and PALS Annual Report 2022-23

13 10:55 - Annual Patient Experience Report
Chief of Corporate Services
13. Patient Experience Annual Report 2022-23

14 11:00 - Performance Report
Chief Operating Officer
14. 2023-24 Executive Summary M06 Coversheet
14.1 2023-24 Executive Summary M06
14.2 2023-24 Board Scorecard M6

15 11:05 - GIRFT Elective Update
Chief Operating Officer

16 11:10 - Finance Report
Chief Finance Officer
16. Finance Report Month 6 Public Board

17 11:20 - Workforce Report
Chief People Officer
17. Workforce Report M6 2022-23 Board

18 11:25 - Freedom to Speak Up
Chief People Officer
18. FTSU Board Report 6m 2023-24

19 11:30 - Green Plan Update
Chief Finance Officer

20 11:35 - 2022/23 Annual Infection Prevention and Control Report
Chief Medical Officer
20. IPC annual report 2023 (003)

21 11:40 - Research & Development Annual Report
Chief Medical Officer
21. RandD annual Report 2022 23

22 11:45 - Guardian of Safe Working Hours Annual Report (2022 - 2023)
Chief Medical Officer
22. GOSWH Report 2022-2023

23 11:50 - Risk Register Report
Chief Corporate Services Officer
23a. Trust Board - 2nd November 2023 - Risk Register

23b. Corporate Risk Register - as at 31st October 2023

24 11:55 - Board Assurance Framework
Chief Corporate Services Officer
24. Board Assurance Framework November 23

25 12:00 - Update to the Terms of Reference of the Board and its Committees
Chief Corporate Services Officer
25a. Board of Directors Terms of Reference November 2023 Coversheet
25a2. Board of Directors Terms of Reference 2023
25b. Audit Committee Terms of Reference September 2023 Coversheet
25b2. Audit Committee ToR September 2023
25c. Charitable Funds Committee Terms of Reference October 2023 Coversheet
25c2. Charitable Funds Committee Terms of Reference September 2023
25d. FIC Terms of Reference September 2023 Coversheet
25d2. FIC Terms of Reference September 2023
25e. QCRC Terms of Reference September 2023
25e2. QCRC Terms of Reference September 2023
25f. WDAC Terms of Reference November 2023 Coversheet
25f2. Workforce and Development Assurance Committee ToR Nov 2023

26 12:05 - Summary Reports
Chairs of Board Committees
26a. Audit Committee Summary Report 18.09.2023
26b1. FIC 01.08.2023 Board Committee Summary Report
26b2. FIC 05.09.2023 Board Committee Summary Report
26b3. FIC 25.09.2023 Board Committee Summary Report
26c. TEC Board Committee Summary Report 13.09.23

27 12:10 - Use of Trust Seal
Chief Corporate Services Officer
27. Use of Trust Seal October 2023 v 2

28 12:15 - Forward Agenda Planner
Chair
28. Trust Board Meeting In Public Forward Agenda Planner v

Chair

30 12:23 - Motion To Close The Meeting

Chair

31 12:26 - 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."

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10:00 am on Thursday 02 November 2023
in the Conference Room at the Academic Centre and via MS Teams

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10:00	Apologies	Receive	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda • 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	Chief Nursing Officer	Presentation To Follow
4		Minutes of the Trust Board meeting held in public on 07 September 2023	Approve	Chair	Attached
5		Matters Arising and Action Log	Note	Chair	Attached
Chair and Chief Executive Updates					
6	10:20	Chair's Report	Information	Chair	Attached
7	10:25	Chief Executive's Report a. External Reviews and Support - Organisational and Board Culture b. BLMK ICB September 2023 c. The Denny Review: A review of health	Receive and Discuss Receive and Discuss Note	Chief Executive	Verbal Attached Attached

Item No.	Timing	Title	Purpose	Lead	Paper
		inequalities in Bedfordshire, Luton and Milton Keynes	Note		Attached
Patient Safety					
8	10:35	Serious Incident and Learning Report	Receive and Discuss	Chief Medical Officer	Attached
9	10:40	Mortality Update	Receive and Discuss	Chief Medical Officer	Attached
Patient Experience					
10	10:45	Maternity Assurance Group Update	Receive and Discuss	Chief Nursing Officer	Attached
11	10:50	Safeguarding Annual Report	Receive and Discuss	Chief Nursing Officer	Attached
12	10:55	Annual Complaints Report	Receive and Discuss	Chief of Corporate Services	Attached
13	11:00	Annual Patient Experience Report	Receive and Discuss	Chief of Corporate Services	Attached
Performance					
14	11:05	Performance Report 06	Receive and Discuss	Chief Operating Officer	Attached
15	11:15	GIRFT Elective Update	Receive and Discuss	Chief Operating Officer	To Follow
Finance					
16	11:20	Finance Report 06	Receive and Discuss	Chief Finance Officer	Attached
Workforce					
17	11:30	Workforce Report 06	Receive and Discuss	Chief People Officer	Attached
18	11:35	Freedom to Speak Up	Receive and Discuss	Chief People Officer	Attached
19	**Break – 11:40**				
Assurance and Statutory Items					
20	11:50	2022/23 Annual Infection Prevention and Control Report	Receive and Discuss	Chief Medical Officer	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
21	11:55	Research & Development Annual Report	Receive and Discuss	Chief Medical Officer	Attached
22	12:00	Guardian of Safe Working Hours Annual Report (2022 - 2023)	Receive and Discuss	Chief Medical Officer	Attached
23	12:05	Risk Register Report	Receive and Discuss	Chief Corporate Services Officer	Attached
24	12:10	Board Assurance Framework	Receive and Discuss	Chief Corporate Services Officer	Attached
25	12:15	Update to the Terms of Reference of the Board and its Committees a. Board of Directors b. Audit Committee c. Charitable Funds Committee d. Finance and investment Committee e. Quality and Clinical Risk Committee f. Workforce and Development Assurance Committee	Approve	Chief Corporate Services Officer	Attached
26		(Summary Reports) Board Committees a. Audit Committee 18/09/2023 b. Finance Committee 01/08/2023, 05/09/2023 and 25/09/2023 c. Trust Executive Committee 13/09/2023	Assurance and Information	Chairs of Board Committees	Attached
27		Use of Trust Seal	Note	Chief Corporate Services Officer	Attached
Administration and Closing					
28	12:25	Forward Agenda Planner	Information	Chair	Attached

Item No.	Timing	Title	Purpose	Lead	Paper
29		Questions from Members of the Public	Receive and Respond	Chair	Verbal
30		Motion To Close The Meeting	Receive	Chair	Verbal
31		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, 11 January 2024					

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 07 September 2023 at 10.30 hours in the Academic Centre, Milton Keynes University Hospital Campus and via Teams

Present:		
Alison Davis	Chair	(AD)
Joe Harrison	Chief Executive Officer	(JH)
John Blakesley	Deputy Chief Executive	(JB)
Bev Messinger	Non-Executive Director	(BM)
Gary Marven	Non-Executive Director	(GM)
Mark Versallion	Non-Executive Director	(MV)
Haider Husain	Non-Executive Director	(HH)
Heidi Travis	Non-Executive Director	(HT)
Dr Ian Reckless	Chief Medical Officer	(IR)
Danielle Petch	Chief People Officer	(DP)
Yvonne Christley	Chief Nursing Officer	(YC)
Emma Livesley	Chief Operating Officer	(EL)
Terry Whittle	Chief Finance Officer	(TW)

In Attendance:		
Kate Jarman	Chief Corporate Services Officer	(KJ)
Jason Sinclair	Associate Non-Executive Director	(JS)
Ganesh Baliah	Associate Non-Executive Director	(GB)
Johanna Hrycak (Item 3)	Project Manager-General Transformation	(JH)
Sharon Robertson (Item 3)	Matron for Patient & Family Experience	(SR)
Nicholas Mann	Business Leaders Representative	(NM)
Oli Chandler	Head of I.T. Technical Services	(OC)
Taofik Balogun	Inspector, Care Quality Commission	(TB)
Christine Thompson	Public Governor	(CT)
Stevie Jones	Staff Governor	(SJ)
Tracy Rea	Staff Governor	(TR)
Yolanda Potter	Staff Governor	(YP)
Maxine Taffetani	Representative Governor, Milton Keynes Health Watch	(MT)
Kwame Mensa-Bonsu	Trust Secretary	(KMB)
Timi Achom	Assistant Trust Secretary	(TA)

1 Welcome and Apologies

1.1 AD welcomed all present to the meeting. There were apologies from Precious Zumbika-Lwanga (Associate Non-Executive Director) and Dr Dev Ahuja (Non-Executive Director).

2 Declarations of interest

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

3 Patient Story

3.1 AD introduced JH and SH who presented the journey and difficulties faced by veterans and their families/carers and support provided by the Armed Forces volunteers.

3.2 Veteran "*Dave*" had served as a warrant officer for 20 years in the Armed Forces and was unprepared for civilian life following his end of contract. He was disconnected from his family and suffered financial abuse in later years. Dave missed the brotherhood and banter that came with service life and

unresolved issues from his service in Northern Ireland led to struggles with mental health and alcohol as Dave felt he could not ask for help.

3.3 Dave's life was chaotic after his military service and some of his lifestyle choices resulted in him falling ill and becoming immobile. Dave was exceptionally badly burnt in a house fire which occurred July 2022 as he was unable to get himself out safely. He was transferred to the Trust from the Queen Elizabeth Hospital, Birmingham in March 2023.

3.4 The Armed Forces volunteers provided immediate support to Dave and with his consent contacted a roommate from basic training in 1974 and they remained in contact until his death in June 2023. Dave was given a public health funeral supported by the Royal British Legion.

3.5 JH also highlighted the support provided by volunteers and the progress over the last two years since signing the Armed Forces Covenant in May 2021. This included an Armed Forces Gold award for the Employer Recognition Scheme and a *purple tick* award which was an Armed Forces Veterans Aware accreditation recognising the Trust's work identifying and sharing best practice across the NHS as an exemplar of the best standards of care for the Armed Forces community.

3.6 On behalf of the Board, AD thanked JH and SH for the presentation.

4 Minutes of the Trust Board Meeting in Public held on 06 July 2023

4.1 The minutes of the Trust Board Meeting in Public held on 06 July 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 January 2024

Action 31 CQC Maternity Patient Experience Update

A presentation on patient experience themes and data to be provided at the October 2023 Board Seminar.

There were no other matters arising.

6 Chair's Report

6.1 AD provided an update from the Inclusion Leadership Council meeting which was held in September 2023. She advised of the discussion around NHS equality, diversity and inclusion action plan and implementation and the "See Me First" initiative which was linked to inclusion and equality.

6.2 AD advised the Board that the Trust would be holding several events and training sessions as part of Black History Month in October 2023 which would be led by the Black, Asian and Minority Ethnic (BAME) Staff Network. She added that October 2023 was also the Freedom to Speak Up month (FTSU) and that the Trust would be holding a range of activities including the promoting of Freedom to Speak Up by Guardians and Champions.

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

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

7.1 JH announced that the Prime Minister paid a visit to the Trust in August 2023 where the fantastic work that was going on across the hospital to deliver exceptional care to patients was showcased. The Prime

Minister recognised and acknowledged all the incredible work that was being undertaken every day by members of staff.

7.2 Operational pressures

The organisation continued to experience operational constraints with industrial strikes continuing in August 2023 with ongoing impact on finances and elective waiting list. In terms of the position going forward, IR advised that further industrial strikes were planned for Tuesday 19 September until Wednesday 20 September and additionally, for 72 hours from Monday 02 October to Thursday 05 October.

Elective Care Priorities

EL presented the Elective Care Priorities report asking the Board to review the checklist and the Trust's current position against the self-certification process before submission to NHS England by 30th September 2023. A detailed update would be provided to the Finance and Investment Committee (FIC), prior to 30th September submission. JH added that the self-certification process was set up without the implications of the strike action.

BLMK Health and Care Partnership and Integrated Care Board Update

JH advised that the Reverend Lloyd Denny from Luton had been working with health and social care partners and residents of BLMK to undertake a root and branch review of health inequalities in the community. Reverend Denny would publish his independent report in mid-September 2023, setting out the recommendations based on the insights gathered. The Integrated Care Board (ICB) would then provide a formal response to outline how the recommendations would be taken forward. The report would be shared with the Board in due course.

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

8 Serious Incident and Learning Report

8.1 IR presented the report and highlighted the following as part of his overall report:

1. 9 incidents were reported in the reporting period which were all under investigation. Findings from the investigations would be reviewed by the Quality and Clinical Risk Committee.

2. In the last 12 months, three incidents had occurred where patients had or appeared to have choked or aspirated on food and sadly died.. Each incident was investigated, learning shared and a systemic programme of work and review of current practice was undertaken.

3. The Trust received an unexpected Regulation 28 Report from HM Coroner in August 2023. The conclusion of the inquest was narrative; the patient died as a result of a haemoperitoneum after the insertion of a Percutaneous endoscopic gastrostomy (PEG) tube. IR advised that this was a recognised complication of a necessary medical procedure. Areas of concern would be addressed by the Trust to the HM Coroner in due course.

4. The Trust had been piloting the new Patient Safety Incident Response Framework (PSIRF) approach to investigation in three clinical areas. A consultation with the Clinical Governance Department had just concluded, which reorganised roles to better align Patient Safety Incident Response Framework (PSIRF) and the Trust's commitment to both patient safety and quality improvement. This reorganisation better aligned roles and resources to specialist safety roles, and to the functions of clinical audit, workplace risk and improvement and learning.

8.2 In response to the query around compulsory sepsis training, IR advised that the deteriorating patient training is a mandatory eLearning course for relevant staff and that sepsis training was incorporated as part of this. In addition to this, KJ stated that Quality Improvement Programmes were running across the organisation as part of ongoing work around sepsis.

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

9 Patient Experience

9.1 YC presented the report providing updates around Maternity Assurance Group and Maternity staffing.

9.2 YC advised of the forecast and the potential impact of increased antenatal booking on births, and subsequent pressure on the service. Discussions to increase elective theatre capacity and an analysis to include national length of stay for elective sections compared to MKUH and of births by month over the past three years was underway.

9.3 There was a slight increase in admissions to Neonatal Unit in April, May and June 2023 in part due to the lack of availability of Transitional Care and partly due to unavoidable respiratory problems. A respiratory Avoiding Term Admissions Into Neonatal units (ATAIN) action plan was part of the overall maternity quality improvement tracker and a business case to increase Transitional Care had been developed and submitted to the Clinical Board Investment Group (CBIG).

9.4 In terms of Maternity staffing, the Trust was compliant with the Anaesthesia Clinical Services Accreditation (ACSA) standard, roles and responsibilities of the Royal College of Obstetricians and Gynaecologists and fully compliant with the British Association of Perinatal Medicine national standards for medical staffing. There was ongoing focus around improved position for overall Maternity workforce.

9.5 In response to a question about the red flags in the report, it was explained there was a staffing red flag warning which signified that midwifery staffing did not meet the acuity and activity at a certain time. If a staffing red flag event occurred, the registered midwife in charge of the service would be notified and necessary action taken to resolve the situation. There were 147 red flags raised between February and July 2023. Consultant Midwives were conducting audits to identify necessary improvements and the Maternity Voices Partnership was also collaborating with the Trust and the multidisciplinary team to improve the delivery of the pathway.

9.6 The Board **noted** the Patient Experience report.

10 Performance Report for Month 04 (July 2023)

10.1 EL presented the Performance Report for month 04. There was a slight improvement in the emergency care pathway with the percentage of attendances admitted, transferred or discharged within 4 hours at 75.3% when compared to June 2023. This was despite a challenging month of ongoing industrial strikes. There was a reduction in non-criteria to reside from 102 in month 03 (June 2023) to 71 in month 04 (July 2023) which was attributed to closure of escalation beds.

10.2 In terms of the elective pathway, there was a slight increase in elective spells. There were 2,259 elective spells in July 2023, an increase of 120 spells from June 2023. Overall diagnostic performance was impacted by MRI staffing lacking the availability to secure agency staff.

10.3 The Board **noted** the Performance Report for Month 04 (July 2023)

11 Finance Report for Month 04 (July 2023)

11.1 TW reported a £5.9m deficit to the end of July 2023. This was £6.2m worse than plan. The plan for the year (2023) was break even and therefore the deficit corresponded against the variants from a planning perspective.

11.2 There was 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 was improving as actions to reduce expenditure came into effect.

11.3 The savings target for the year was £17m (5% of expenditure). £5.8m of this was expected to be delivered to July 2023. A low value of schemes was transacted during Q1, and significant improvement

had been made during July 2023. In terms of operating expenses, non-pay was above plan due to additional spend on drugs (£1.4m). There had been some supply chain pressures in terms of the provision and availability of certain categories of drugs. There was ongoing work with the Trust's Chief Pharmacist and Procurement to ensure appropriate substitution was available.

11.4 Capital expenditure was £1.3m below plan, due to the delay in resolving the capital shortfall. The Trust was awaiting approval for the £5m shortfall in the approved 23/24 Integrated care systems (ICS) Capital departmental expenditure limit (CDEL) allocation.

11.5 Following discussions between the Trust and NHS England, TW reported that a confirmation of the final elective recovery funding target for the year 2023/24 had been received. This was set at 104% from 106% considering the impact of the strike action in April 2023. Further adjustments were expected following the industrial strikes in June, July and August 2023.

11.6 The Board **noted** the Finance Report for Month 04 (July 2023).

12 Workforce Report for Month

12.1 DP highlighted the following from the report.

1. Temporary staffing usage had gradually reduced over the past 4 months with an improvement in cost. Work continued to ensure scrutiny of all agency spend, with detailed requests for agency being signed off by the Executive Lead prior to booking.

2. The Trust's headcount continued to increase and there were now 4293 employees in post in the Trust, which was the highest it had ever been, with an additional 363 staff in post compared to the same period in 2022/23. The vacancy rate continued to decrease with improvements across several staff groups.

3. '*Time to hire'* increased to 50 days and was likely to be further impacted as problems with the national recruitment systems following a software update had resulted in the intermittent closure of the national Trac recruitment system during Month 04 (July 2023). This was expected to have an ongoing impact on the 'time to hire' metric for the next few months.

4. The number of open disciplinary cases had reduced with several hearings taking place in Month 03 (July 2023) and Month 04 (July 2023). A detailed Employee Relations case report was produced monthly to Joint Consultation and Negotiation Committee (JCNC) and an annual report was presented to Workforce Development and Assurance Committee.

5. There were 59.3 nursing vacancies across the Trust. The fourth cohort of the 2023 intake of internationally educated nurses arrived in Month 04 (July 2023), consisting of 22 nurses. There were currently 23 international and 17 UK-trained nurses in the recruitment pipeline.

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

7. The Staff Survey was due to launch in Month 07 (October 2023) as part of the Trust's annual Protect and Reflect Event, with Covid and Flu Vaccinations being offered to staff whilst they completed their survey.

8. The revised NHS Fit and Proper Person Test Framework was published in Month 05 (August 2023) and the Trust had updated its policy to ensure that recruitment and assessment of its Board Members was comprehensive and compliant. The implementation date for the revised processes was 30 September 2023.

9. The Trust's Freedom to Speak Up (FTSU) Policy had been reviewed to ensure that it was compliant with the national framework and template policy. The 3-year strategy for Freedom to Speak Up

(FTSU) was being reviewed, with recruitment underway for additional Freedom to Speak Up (FTSU) Champions, as well as the planned implementation of the Freedom to Speak Up (FTSU) App for staff, giving them an additional mode of contacting the Freedom to Speak Up (FTSU) Team.

12.2 JH applauded the workforce team and stated that mandatory training and appraisals had exceeded expectations for more than a year and that vacancy rate had also decreased.

12.3 The Board **noted** the Workforce Report for Month 04.

13 Medical Revalidation – Statement of Compliance

13.1 IR presented the Medical Revalidation Statement of Compliance report. He stated that the Trust maintained robust processes to support doctors through their appraisals and revalidation. The annual revalidation audit had not identified any concerning trends.

13.2 The Board **noted** the Medical Revalidation – Statement of Compliance

14 Emergency Preparedness Resilience and Response (EPRR) Annual Assurance Review 2023

14.1 EL presented the Emergency Preparedness Resilience and Response (EPRR) Annual Assurance Review 2023 report advising that the Self-Assessment showed a 97% compliance with core standard questions resulting in the Trust being rated as being at the 'Substantial Compliance Level'. An action plan had been developed to ensure the Trust moved from 'Substantial' to 'Fully Compliant' prior to 2024 Core Standards submission.

14.1 The Board **noted** the Emergency Preparedness Resilience and Response (EPRR) Annual Assurance Review 2023 Report.

15 Risk Register Report

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

16 Board Assurance Framework

18.1 The Board **noted** the Board Assurance Framework

17 Board Committees Summary Reports

17.1.1 Summary Report for the Audit Committee – 17 July 2023

17.1.2 The Board **noted** the report.

17.1.3 Summary Report for the Finance and Investment Committee Meeting – 06 June 2023 and 04 July 2023.

17.1.4 The Board **noted** the report.

17.1.5 Summary Report for the Trust Executive Committee – 12 July 2023 and 09 August 2023.

17.1.6 The Board **noted** the report.

17.1.7 Summary Report for the Charitable Funds Committee – 20 July 2023

17.1.8 The Board **noted** the report.

18 Forward Agenda Planner

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

19 Questions from Members of the Public

19.1 There were no questions from the public.

20 Any Other Business

20.1 There was no other business.

20.2 The meeting closed at 12:42pm

Updated : 27/10/23

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Trust Board Action Log

Action No.	Date added to log	Agenda Item No.	Subject	Action	Owner	Completion Date	Update	Status Open/ Closed
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	Completed

Meeting Title	**Trust Board**	**Date: 02.11.2023**
Report Title	**Chair's Report**	**Agenda Item Number: 6**
Lead Director	Alison Davis, Chair of the Trust Board	
Report Author	Alison Davis, Chair of the Trust Board	

Introduction	To provide details of activities, other than routine committee attendance, and matters to note to the Trust Board:		
Key Messages to Note	An update for the Board on activity and points of interest including: • NHS Equality, Diversity and Inclusion Improvement Plan • The appointment of a new Chief Finance Officer • October Black History and Freedom to Speak Up month • The Denny 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)*	N/A

Report History	N/A
Next Steps	
Appendices/Attachments	Chair's Report

Chair's report: Oct 2023

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

1. In September I attended the NHS England (NHSE) Chairs and Chief Executives conference. Discussions focused on the Letby verdict and the next steps for the NHS; waiting list reduction progress and industrial action impact; the NHS Equality, Diversity and Inclusion(EDI) Plan launched in the summer and implementation of the High Impact Priorities
   The link for the EDI plan is :-
   NHS England » NHS equality, diversity, and inclusion improvement plan

2. We held a successful interview process in September for the appointment of a new Chief Financial Officer. Joe Harrison will provide a further update.

3. There were events during October to celebrate Black History Month and Freedom to Speak Up (FTSU) Month, including :
   - Encouraging members of staff to make FTSU pledges
   - FTSU Guardians raising awareness around the organisation
   - Celebrating Diversity Event in the Tent, including music, food, clothing and jewellery—it was lively!
   - Online presentations and discussions with Inspiring Women

4. An Admin Appreciation Day was held on the 27th September to recognise the many members of the MKUH Team who provide vital support in the delivery of our services.

5. I visited the robotic assisted surgery theatre again to see the team using the technology performing an operation, which was highly impressive. I also visited the Neonatal services to see the changes made recently to relieve some of the challenges the limited space presents on a daily basis. We are still hoping to hear about the funding for our new hospital soon.

6. The Denny review, commissioned by the BLMK Integrated Care Board has been published, looking at health inequalities across the Integrated Care System. The report and background to it can be found at Tackling inequality in Milton Keynes: the Denny Review | Healthwatch Milton Keynes

   A response will be provided at the Integrated Care Board in December, and the meeting can be followed at Board Meetings - BLMK Integrated Care Board (icb.nhs.uk)

Chief Executive's Report: External Reviews and Support

Introduction

In consultation with the Chair and the Executive, I am commissioning external reviews and support in a number of areas to help strengthen and develop the organisational culture here at MKUH – particularly in relation to equality and the active dismantling of structures, systems or behaviours that contribute to inequality.

I briefed the Board verbally on our intention to conduct this work last month and would like to take the opportunity to formally report the scope of the work being commissioned.

I would also like to formally invite Non-Executive Directors of the Board to contribute to shaping the terms of reference of these pieces of work – this can be done to me directly, to the Chair, or to Kate Jarman as Director of Governance (who will lead on co-ordinating these pieces of work), or to Kwame Mensa-Bonsu as Trust Secretary.

External Reviews and Support

1. Organisational culture development programme focussed on anti-racism/ tackling racism and racial inequality – led by an independent external expert. An approach has been made to Roger Kline, an expert in workplace culture and author of 'The Snowy White Peaks of the NHS'. An initial meeting takes place week commencing 6th November.
   An approach has additionally been made to Lord Victor Adebowale, chair of the NHS Confederation to approach Yvonne Coghill, another recognised leading expert in racial equality.

2. External review of Human Resources – led by an independent barrister (KC) with expertise in employment law (unconnected to the Trust/ not one of the Trust's panel firms). An approach has been made to a KC who is specialist in employment and discrimination law.

3. External review of Board papers – NHS England has been invited to nominate an expert in board governance to review Board papers to provide external assurance that the Board is appropriately covering the breadth and depth of issues under its remit, including through delegated authority at Committees

4. The Care Quality Commission will be working with the Trust to explore the lived experience of Black, Asian and Minority Ethnic members of staff and review WRES data and reports. This will be fed back to the Trust via a formal letter.

In addition to the above I have included a link below to the recently published report from NHS Providers focused on “Closing the Gap: A guide to addressing racial discrimination in disciplinaries”.

https://nhsproviders.org/closing-the-gap-a-guide-to-addressing-racial-discrimination-in-disciplinaries

Reporting

All feedback and reports from these reviews will be received in a Board meeting held in public. In months where there is no Board meeting in public, an update will be provided to the private meeting of the Board, and repeated in public (with relevant updates from the intervening time period) included.

Joe Harrison
Chief Executive Officer

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date 2 November 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: Board of Directors, Milton Keynes University Hospital NHS Foundation Trust

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

1.0 Executive Summary

1.1 This report summarises key items of business from the BLMK Integrated Care Board that are relevant to Milton Keynes University Hospital NHS Foundation Trust. The BLMK Health and Care Partnership (ICP) is due to meet on 31 October 2023.

2.0 Recommendations

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

3.0 Key Implications

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

3.1 This report provides a summary of items discussed by the ICB and ICP. Each individual report considered at those meetings identifies the relevant implications as listed above.

4.0 Report

4.1 Annual General Meeting (AGM)

The Annual General Meeting (AGM) of the Integrated Care Board took place before the usual Board meeting. Chair Dr Rima Makarem, Chief Executive Felicity Cox and Deputy Chief Finance Officer Stephen Makin provided an overview of 2022/23, including the break-even financial position achieved by the ICB. Also presented were the Annual Reports for BLMK Clinical Commissioning Group for Months 1 - 3 of 2022/23 and for BLMK ICB for Months 4 - 12. Both Annual Reports can be found here on the ICB's website: https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/our-publications/annual-reports-1/.

4.2 Bedfordshire, Luton and Milton Keynes Integrated Care Board

The Board of the ICB met on 29 September 2023, the communications summary from the meeting is given below.

4.2.2 The Integrated Care Board meeting followed the AGM. Felicity Cox provided an overview of work underway to prepare for the planned industrial action from consultants and junior

doctors week commencing 2 October 2023 and informed the Board that, following inspections, there was no reinforced autoclaved aerated concrete (RAAC) in BLMK's NHS estates. The Board celebrated the news that Head of the BLMK Cancer Network, Kathy Nelson, had been named Ground-breaking Researcher of the Year Award at the national BAME Health and Care Awards in London on 28 September 2023.

4.2.3 There was one question from the public about how the ICB plans to fund the East of England (South) Integrated Stroke Delivery Network. Chief Nursing Director, Sarah Stanley outlined that the ICB is committed to the concept of Integrated Stroke Delivery Networks and is working with partner ICBs, and regional and national colleagues, to consider how these could best be supported in an affordable and sustainable way. She acknowledged the hard work of all local health and care staff who provide direct or indirect support to those affected by strokes.

4.2.4 The following items were discussed:

1. **Resident's story** – members watched a video from Catherine, a resident from Bedford who is deaf. She shared her powerful story in BSL. She explained the challenges that people who are deaf face when accessing health and care, including being able to make or change an appointment and engage with health and care professionals. The Board reflected on the need to think about and change how we communicate to ensure easy and fair access for everyone – a key part of the Denny Review (attached to the meeting pack) of Health Inequalities.

2. **Health and Employment Outline Strategy** – The Board heard how Places are taking forward the action plans arising from the ICB's Health and Employment Seminar in July 2023, and the report presented at the Seminar can be found here: https://blmkhealthandcarepartnership.org/health-and-care-partners-commit-to-tackling-major-employment-and-health-challenges/. These action plans include efforts to maximise the support from Anchor Institutions, make full use of the Apprenticeship Levy and broaden volunteering opportunities. The Chief People Officer for the ICB outlined what the ICB will be working on to support residents in applying for work in the health and care system. The Chief People Officer also shared examples of recent work, such as a campaign to support residents without easy access to the internet to hear about job opportunities. It was confirmed that VCSE organisations would be central to supporting the development and implementation of new Health and Employment Strategy for BLMK, an outline of which will come to the BLMK Integrated Care Partnership meeting on 31 October.

3. **Mental Health, disabilities and autism** – The Board supported work to develop a new Mental Health, Disabilities and Autism collaborative in BLMK that would encourage more joined up working across the system, with focused work at place to deliver care closer to those who need it. The Board heard how a model for new ways of working was in development and asked for more information on how Primary Care Networks (PCNs) and GP surgeries would fit into the model. The Board asked for more detailed work to be undertaken around the governance and membership as the collaborative emerges.

4. **Equality, Diversity and Inclusion** – the Chief People Officer for BLMK took the Board through six areas where focus is needed to help us retain our health and care workforce. Providing a living wage for staff and creating the right culture was the focus of the discussion, including ensuring that all people are empowered to 'speak up'. Partner

organisations were invited to reflect on the culture of their organisations and endorse the action areas to support their people in thriving at work.

5. **Financial and operational reports** – members received formal updates from quality and performance, finance and governance, as well as an update on Section 75 agreements from local authority chief executives, which were agreed by the Board. The Chief Transformation Officer provided assurance on urgent and emergency care and the Board approved the plan, in line with NHSE requirements and thanked partners for their efforts in working together to maintain system flow. Clinical members asked that officers continue to work to a prevention agenda to support people in keeping well and encouraged neighbourhoods to lead the way on this work. The roll out of virtual wards was commended as among the best performing in the England. The Board added a strategic risk to its register to respond to the challenge of health literacy in our population as highlighted by the Denny Review.

4.3 Other ICB Updates

4.3.1 Specialised commissioning – ICB Board 28 July 2023

An extra-ordinary meeting of the ICB Private Board took place on 28 July to consider the delegation and hosting of 59 specialised commissioning services which will be delegated to ICBs from 1 April 2024. The specialised commissioning service 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 acute provider in its area (although both MKUHFT and BHFT do provide some services under the specialised banner) 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 BLMK ICB hosting 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.

4.3.2 Denny Review into Health Inequalities (Attached to the meeting pack)

The Denny Review into Health Inequalities across Bedfordshire, Luton and Milton Keynes was published in September 2023 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. The ICB Board will be issuing its formal response to the review in December 2023.

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 VCSE partners led engagement with different communities to understand in-depth the lived experiences of these seldom-heard groups. In MK, this work was undertaken by Healthwatch MK, Community Action: MK and the YMCA the reports can be found here: https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/wp-content/uploads/sites/6/2023/06/Agenda-Item-6.1-Background-Reading-documets.pdf.
(A joint summary report of the MK findings starts on page 204).

On publication of the Healthwatch and VCSE 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".

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

5.0 Next Steps

None

The Denny Review

A review of health inequalities in Bedfordshire, Luton and Milton Keynes

September 2023

Contents

Foreword P3

Executive summary P5

Introduction P8

Terms of reference P11

What we heard P13

Published evidence P14

Listening to residents P20

Gypsy, Roma, Traveller community P21

Women from migrant backgrounds P22

LGBT+ people P25

People who have experienced homelessness P27

People with a physical or learning disability P28

Insights and themes P30

Recommendations P34

Short-term change P34

Long-term change P37

Embedding the recommendations P39

Conclusion P40

Steering Group members P42

Participant organisations P43

Commissioned by

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Now is the time for change

Foreword by Reverend Lloyd Denny DL

As a local pastor working in the heart of Luton, I listen to people's stories each day.

Often people tell me about their health problems. These stem from a range of issues, such as poverty, poor housing and unhealthy lifestyle choices.

When some residents try to get help from our local health and care system, they tell me about the barriers they face. The system, plainly, is not designed for them. I hear very clearly that this experience can be frustrating and often demeaning.

The truth is that some people do much better out of the health and care system than others. And it has hugely significant real-life consequences.

Life expectancy across Bedfordshire, Luton and Milton Keynes varies widely. A typical woman living in a deprived area of Luton, such as Bury Park where I am a Minister, has a life expectancy around six years lower than a woman living in a more affluent part of town. For men, the difference is an even more shocking nine years.

These issues have long been with us. This year marks both 75 years since the NHS was founded, and 75 years since the Empire Windrush brought men and women from the Caribbean to help get Britain back on its feet after the Second World War. It is still people from migrant backgrounds who often face the greatest health inequalities.

I have seen diseases like diabetes become a fact of life for too many people, particularly from our Caribbean and south Asian communities, for lack of education and support about healthy lifestyles. I have seen people not getting the care they need because they don't understand how the health system works. I have seen people die before their time because they cannot afford to travel out of our area to access treatment.

Experiences like this will be familiar to many. Health inequalities are common not just for people from migrant backgrounds, but also people experiencing homelessness, the LGBT+ community, the Gypsy, Roma and Traveller communities, people living in deprived neighbourhoods, and people with learning and physical disabilities. But these experiences, while common, are rarely heard.

This three-year study was triggered by the COVID-19 pandemic, when the data told us that people from ethnic minorities were much more likely to be infected and die from the disease. These people were often on the frontline, supporting us all through the crisis. That is an injustice we cannot let slide.

I was not the only one observing this. A group called the Legacy of Windrush Descendants (LOWD), based in Bedford, called on the NHS in Bedfordshire, Luton and Milton Keynes and their partners to do something about the inequalities people face.

This prompted the study which I was asked to lead, to get to the root cause of health inequalities in our area, and to work with those most affected to tackle the issues head-on.

This report is the culmination of that work. I have no doubt that it will take time to rebuild residents' trust, as will responding to this report in full in a way that delivers the radical change required. However, I am confident that if the recommendations in this report are acted upon, we will be much closer to getting the fair and equal health and care system we all need.

Executive Summary

The Denny Review investigated health-related inequalities in Bedfordshire, Luton and Milton Keynes (BLMK). We have sought to understand where health inequalities are greatest and what can be done to improve the situation for those affected.

A review of the published evidence both in the local area and nationally was commissioned from the University of Sheffield to establish what is known about health inequalities. Local voluntary, community and social enterprises (VCSE), including the four local Healthwatch organisations, engaged directly with local residents, particularly those from under-represented groups.

Our recommendations reflect the evidence gathered, particularly residents' experience.

The factors driving health inequalities

The published evidence explains why some people face much worse health outcomes than others. These are:

These factors often combine to mean that a person facing health inequality is more likely to be in poor health. The following groups are more likely to be affected by health inequalities:

- People living in deprived neighbourhoods
- People from ethnic minorities
- LGBT+ people
- Gypsy, Roma and Traveller people
- People with physical or learning disabilities
- People who have experienced homelessness.

A better, more personalised service needed

Following in-depth engagement work with residents from these groups and beyond, four themes emerged:

1. Cultural competency
2. Communication
3. Access
4. Representation.

Cultural competency

The majority of residents we spoke with felt an understanding of their cultural background was often lacking in healthcare staff.

Examples include:

- Migrant women feeling that their condition was not being taken seriously
- An LGBT+ person being spoken to with the wrong pronouns, even after repeatedly explaining what the correct ones were
- A member of the Gypsy, Roma and Traveller community being treated differently as soon as they said what their background was
- A person with autism being expected to wear a face mask even though the healthcare staff member was told it would make them distressed.

Communication

Linked to cultural competency, many issues with communication were raised by residents.

Issues raised include:

- A lack of interpreters to help migrants access healthcare services
- Communication materials with images and text perceived to exclude LGBT+ people
- The body language of a GP receptionist making a resident feel unwelcome
- Hearing loops not being made available to a deaf person
- A person experiencing homelessness being sent letters which they cannot receive.

Access

Access to services plays a big role in someone either feeling that a service is for them, or if they are excluded from it.

Issues around access include:

- Having services in a location that a person cannot afford to get to
- Having GP appointments at times when a resident cannot attend
- Long waiting times for referrals to specialists
- Not having female-only clinics, which would make it easier for some women, such as victims of male violence, to openly discuss their health.

Representation

The need for residents to feel represented in the services they use is a critical part of those services truly serving all residents.

We know that working with patient participation groups from the beginning of a healthcare project increases its chance of success by 20%. Therefore, we need to make sure that the ability for residents to give their views is clearly available and can be fed into decisions made about services where they live.

Evidence-based recommendations

The evidence we present strongly indicates that large-scale change is needed in how health and care is delivered in Bedfordshire, Luton and Milton Keynes to help rebuild trust with residents that healthcare services are truly for them.

The Denny Review Steering Group has worked together to design a series of recommendations based on the published evidence and the views of residents. These are presented in full from page 38.

Recommendations are broken into:

- **Short-term solutions** that can be implemented quickly, which will help to make an immediate difference to the experience of residents over the next one to two years.
- **Larger changes** to how healthcare is delivered, which residents will see the effect of over the next three to five years.

These recommendations are for the Bedfordshire, Luton and Milton Keynes Health and Care Board, working with the Integrated Care Partnership and local residents, to take forward. Regular updates should be shared on the Partnership's website and social media. A comprehensive update will be published each year so that residents can see that change is happening.

Why the Denny Review is different

The Denny Review comes from the people of Bedfordshire, Luton and Milton Keynes. It is the result of intense engagement with residents, much of which has taken place inside communities that feel forgotten, underrepresented, and left behind. The true test in assessing the success of the response to the Report will be whether those individuals to whom we listened begin, over time, to feel like health and care services are for them, and that the barriers to access are tackled with pace and determination. The Report calls for a bold and radical response from system leaders with a real focus on action, not words.

The Denny Review provides a timely focus to help drive positive change. The introduction of the Integrated Care Board (ICB) sees a fundamental shift to a community-led approach to responding to residents' healthcare needs and a greater focus on stopping health problems from appearing in the first place, rather than just treating them when they do.

In addition, the BLMK ICB has used inequalities funding to invest in VCSE organisations. It has recruited community connectors to work with the communities highlighted in the Denny Review and develop equal partnerships with them. Since the pandemic, discrete programmes to tackle health inequalities have been established in all four unitary authority areas of BLMK.

The Denny Review plays a vital role in holding up a mirror to health and care organisations, showing leaders the reality for many minority groups, and acting as a lightning rod for change.

By bringing all insights and recommendations together and learning from existing best practice, we have the opportunity to ensure that insights from residents reach all areas of health and care. This should lead to more residents consistently experiencing improved care.

Introduction

The Bedfordshire, Luton and Milton Keynes Health Inequalities Review, also known as the Denny Review, was commissioned during the early part of the COVID-19 pandemic.

During 2020, evidence showed that while the effects of the virus were felt by all, people from ethnic minorities were disproportionately affected.

The Government ordered a rapid review to look at the facts, determine causes and make recommendations. That **review**, called Disparities in the Risk and Outcomes of COVID-19, was conducted by Public Health England and published in August 2020.

The purpose of this review is not to go over what already is known nor to look solely at the impact of COVID-19 on different communities. Instead it investigates health inequalities in Bedfordshire, Luton and Milton Keynes (BLMK) in their wider sense.

Wider determinants of health, such as housing, poverty and education, have a considerable and measurable impact on health, and are considered as part of this review.

In partnership with the four local Healthwatch organisations which cover the BLMK area, and a range of other organisations, we listened in depth to communities often described as 'seldom heard'. These include people from ethnic minorities, people with physical and learning disabilities, LGBT+ people, and those living in areas of deprivation.

The BLMK Integrated Care System (BLMK ICS) has developed five strategic priorities to improve the health of the local population. Reducing inequalities is one of these priorities, described as: **In everything we do, we promote equalities in the health and wellbeing of our population**. Reducing health inequalities is also woven through the other four priorities.

But what is clear from the evidence in the pages that follow is that health inequalities are real, and exist due to multiple factors, each of which needs to be tackled. Areas of deprivation tend to have poor housing, fewer green spaces, and poorer levels of education, all of which have an impact on health outcomes.

With the advent of the new Integrated Care System (ICS), there is an opportunity to work together in a more collaborative, integrated and impactful way. And, in doing so, to truly deal with longstanding and deeply entrenched issues.

This Review brings together what is known, and gathers new evidence from people directly experiencing health inequalities.

This allows us to make clear, actionable, time-specific recommendations, which can both start to make changes in the short-term, but also make the longer term, more systemic changes which will make a lasting difference.

The recommendations form part of the ways in which the NHS in Bedfordshire, Luton and Milton Keynes can meet its obligations to the Equality Delivery System (EDS) 2022. The main purpose of the EDS is to help local NHS systems and organisations, in discussion with local partners and residents, review and improve their performance for people with protected characteristics.

This means that a person is legally protected from discrimination due to characteristics such as disability, sex, or race.

Those changes will only happen by working together as a health and care system. That includes NHS organisations, local authorities, VCSE organisations, the faith sector and, of course, residents.

About Bedfordshire, Luton and Milton Keynes residents and their health

Bedfordshire, Luton and Milton Keynes (BLMK) is home to about 1 million people. Its population is projected to grow strongly over the coming years.

There are four Places, each covered by local councils:

- Bedford Borough
- Central Bedfordshire
- Luton
- Milton Keynes

Health in the area is covered by the BLMK Integrated Care System, an Integrated Care Board, and an Integrated Care Partnership.

Integrated Care System (ICS) – a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in the area. In BLMK this is called the BLMK Health and Care Partnership, and it has a website which you can find **here**.

Integrated Care Partnership (ICP) - A statutory committee jointly formed between the NHS integrated care board and local authorities. It brings together partners, including voluntary, charity and social enterprises (VCSE) concerned with improving the care, health and wellbeing of the population.

Integrated Care Board (ICB) – A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services.

Where are the most deprived areas in BLMK?

There are 64 small areas, highlighted on the map below, within Bedfordshire, Luton and Milton Keynes which are among the 20% most deprived in England. These areas have populations of between 1,000 and 3,000.

Of these areas there are:

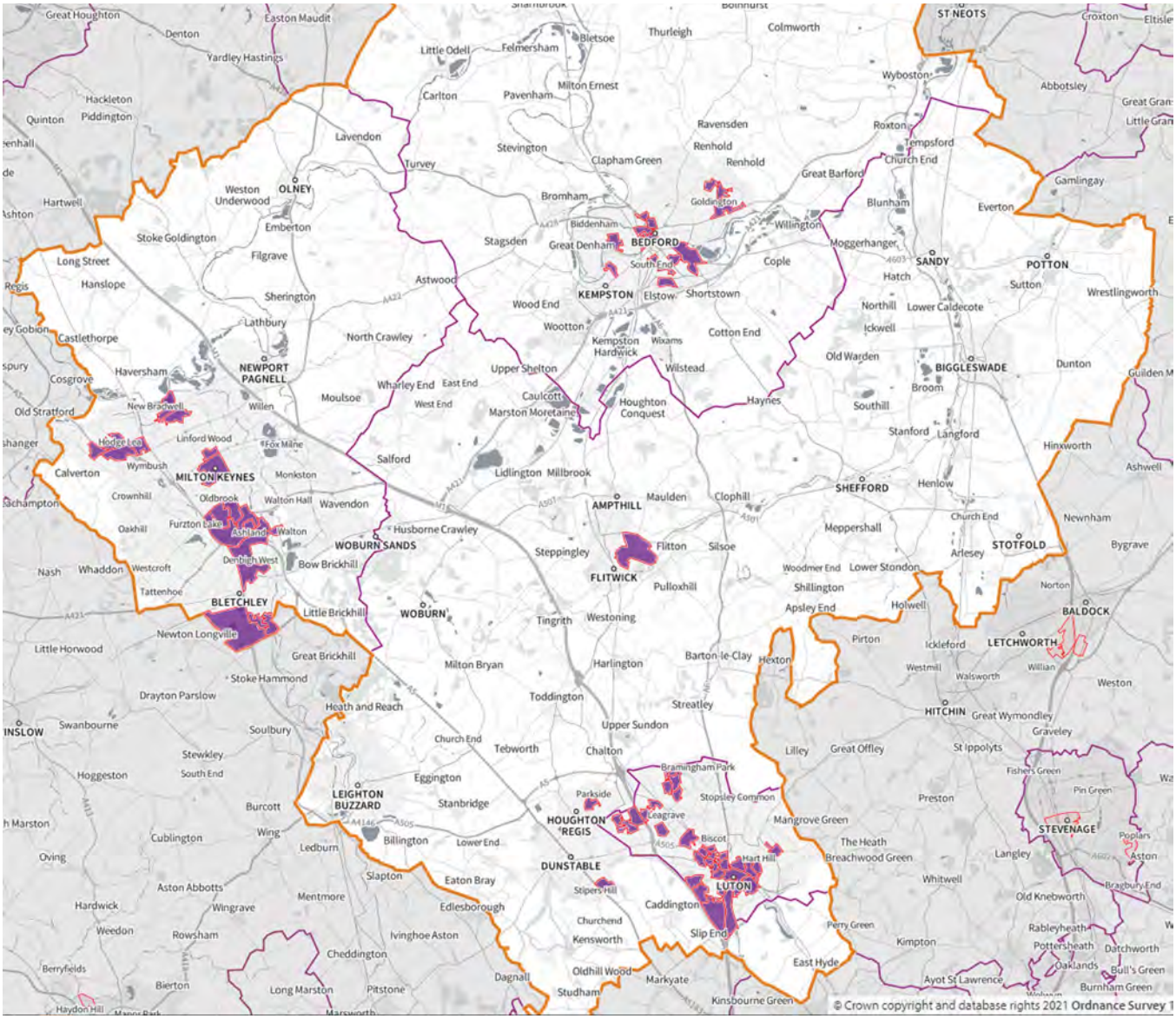
14 in Bedford

3 in Central Bedfordshire

29 in Luton

18 in Milton Keynes

Health inequalities can be found throughout BLMK, but these areas are where residents are most likely to be disadvantaged by the health and care system as it is at present.



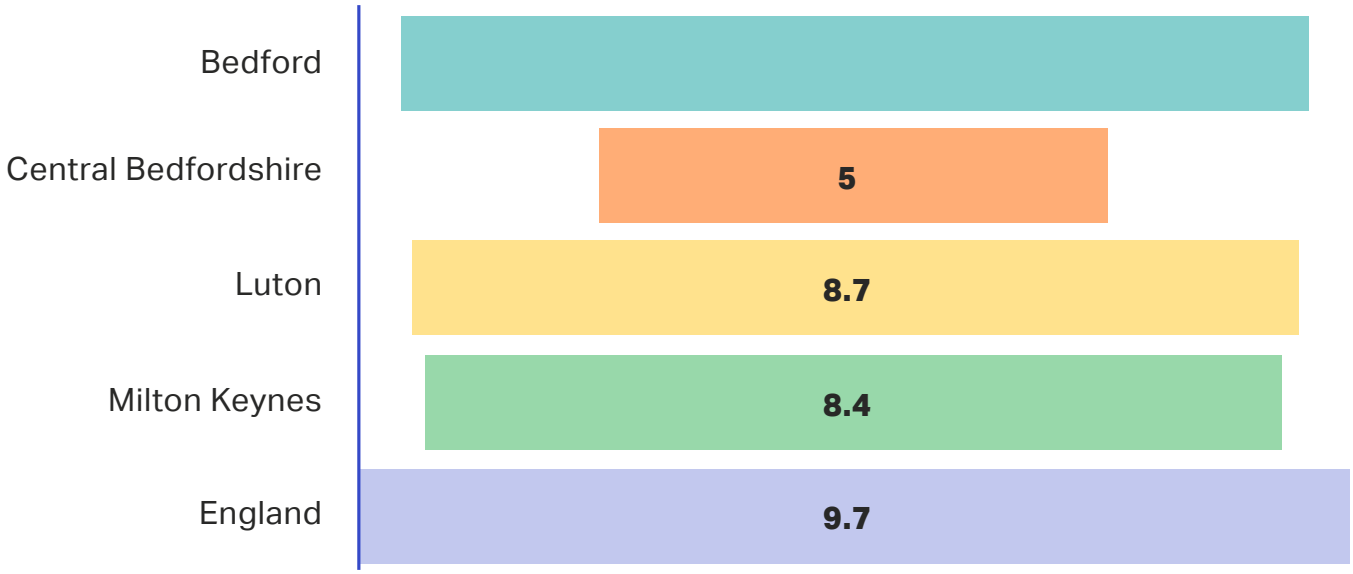
Differences in life expectancy

There are significant differences in life expectancy between people living in the most and least deprived areas of BLMK.

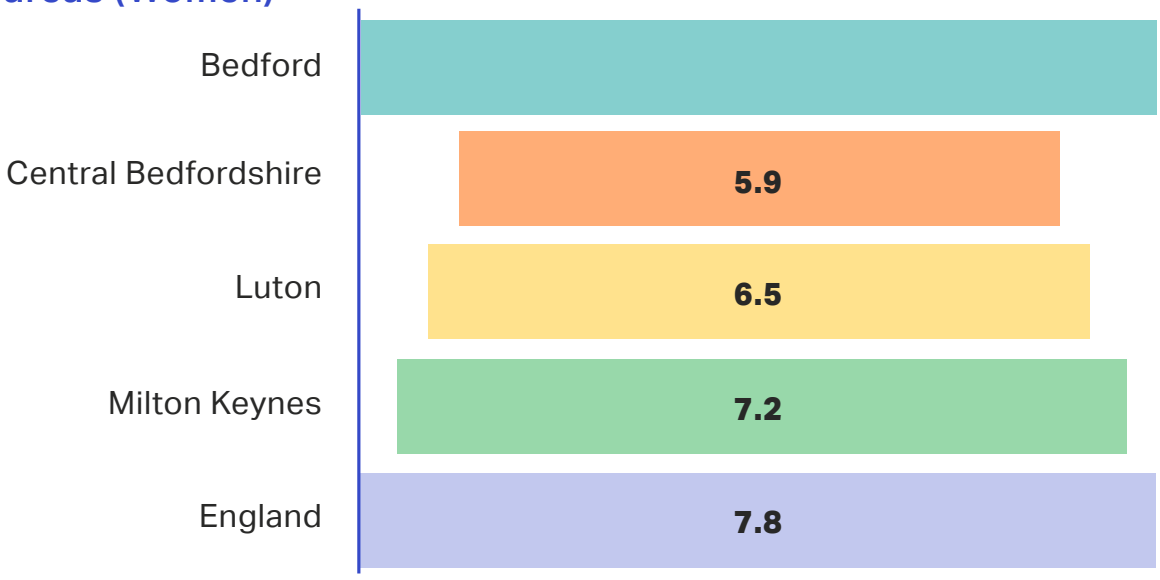
As the chart below shows, a woman living in an affluent part of Central Bedfordshire can expect to live around six years longer than a woman in a deprived area. This difference rises to almost eight years in Bedford.

For men, the difference is even greater. There is a difference of more than eight years between the life expectancy of the least and most deprived areas of Bedford, Luton and Milton Keynes. The differences are, on average, slightly less than the national average, but nevertheless unacceptable.

Difference in life expectancy 2018-20 between most and least deprived areas (Men)



Difference in life expectancy 2018-20 between most and least deprived areas (Women)



Context and terms of reference

In June 2020, the Legacy of Windrush Descendants wrote to the BLMK Clinical Commissioning Group asking that health inequalities be addressed urgently. The charity was responding to emerging evidence that people from black Caribbean and African backgrounds were more adversely affected by the COVID pandemic because of existing inequalities. The Reverend Lloyd Denny was invited to lead a review the following year, when the relaxing of regulations allowed for access to the communities most affected.

A Steering Group was established in the winter of 2020 to agree the methodology for the review and first met in September 2021.

Governance

The Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (from July 2022 the BLMK ICS) leadership commissioned this review to ensure that all inequalities work across the system is informed by an up-to-date evidence base.

This review was led by a dedicated Steering Group. It reported through the BLMK ICS inequalities group, and through that to the ICS Partnership Board.

Remit

The review was led by Reverend Lloyd Denny, former lay board member for patient and public involvement at Luton Clinical Commissioning Group and a respected member of the community.

The review posed the following questions as a starting point to help identify recommendations for the BLMK healthcare system to address:

1. **How were members of different communities affected by COVID-19? What impacts has the pandemic had on health, housing, poverty and education for different groups in BLMK?**
2. **Has the system in the BLMK area done anything to mitigate these inequalities? What are the highest priorities for the system to address based on the evidence?**
3. **What should BLMK ICS do to help address these inequalities, with the maximum impact for residents? What should be done at neighbourhood, place, Care Alliance and system levels?**

This review was based on lived experience and sought evidence from a wide section of our population, paying particular attention to the often-overlooked sections of our population.

Furthermore, the review endeavoured to be transparent and accountable. It was focused on enabling the right actions to be taken to reduce inequalities.

A **virtual library** has been set up to help manage the multiple documents and enable the review to clearly reference the evidence base.

What we heard

A summary of the evidence gathered in the literature review commissioned from the University of Sheffield.

Health inequalities is not a new concept. In commissioning this review, it was important to first review the literature on the health inequalities from different social groups and communities in Bedfordshire, Luton, and Milton Keynes, to ensure that the review had a solid evidence base and took account of the population health data from public health. The review, conducted by the University of Sheffield, also looked at national data on health inequalities, as well as studies of specific groups in different parts of England.

The review set out to address the following research questions:

What information is available on health inequalities in BLMK?

What good practices are there to reduce health inequalities, and what can be learnt from them?

What are the connections between what we know about health inequalities in our area, what are the key themes, and what gaps in our knowledge?

What work does the ICS need to do in collaboration with the communities to improve understanding of people's experiences of inequalities and how to reduce them?

Case study: Mr and Mrs W – experience of accessing care for son with complex needs

Mr and Mrs W live in a deprived part of Central Bedfordshire with their son, who has mental health issues, obsessive compulsive disorder (OCD), autism and severe learning disabilities.

The couple feel that they have been "badly let down" by the Community Mental Health Team, who have not provided consistent support for their son. Mrs W said: "No one takes responsibility, you are just shoved from one person to another."

Their son was prescribed medication but only after he was admitted to a psychiatric ward. Mr W said: "There's no follow-up, no monitoring, no checking on whether the patient is taking the medication, or whether the medication is working."

Mr and Mrs W both feel that healthcare professionals need to find a better way of communicating with him because their son lacks social skills and is very difficult to interact with.

Both parents would like to see a change in the way emergency situations are dealt with. Also, they feel healthcare professionals should be trained to identify people who are under enormous stress, and are not getting the support they need, so they can get help.

More recently, having finally achieved support from the Community Mental Health Team, a support worker visits their son once a week to try to identify their son's needs and how they can help him. Mr W said their son can be responsive to people he feels are 'nice' or who are trying to help him, and he appears to be responding to the weekly visits.

Mr and Mrs W do not feel involved in decisions regarding their son. When they have complained about a service, they either feel that their complaint is 'dismissed' or they are told changes will be made but nothing ever happens. Mrs W said: "In the end I just get fed up because the system doesn't work."

The evidence base

The literature review looked at local evidence identified by the Bedfordshire, Luton and Milton Keynes ICS, including searches of data from the four Healthwatch organisations within the area. Data was also gathered from a range of sources, including health research databases and data from across the NHS, the King's Fund, and the Department of Health and Social Care. For the full list of data sources, go to the literature review document **here**.

Eighty-eight relevant reports were identified, including 71 academic studies or other reports. Seventeen documents were from local health data sources, mostly small studies engaging with specific groups of residents. Nine studies looked at research about the COVID-19 pandemic, and eight papers presented good practice examples.

The review looked at evidence across a person's whole life. These include protective factors, which aid good health, such as a good diet, exercise, good housing, and clean air.

Risk factors, which have a negative effect on a person's health outcomes, include smoking, poor diet, physical inactivity, and harmful alcohol use can lead to preventable diseases and premature deaths.

Looking at these wider determinants of health will help draw out specific ways to improve the conditions into which people are born, live and work.

The literature review paid attention to NHS England and NHS Improvement's approach, Core20PLUS5, to reduce health inequalities (see tables below). It focuses on the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) and five priority areas. It targets the most vulnerable groups and communities identified through population data for addressing health inequalities (NHS England, 2021).

Core 20 + 5 for adults

Core 20 + 5 for children and young people

What the evidence showed

The findings from our commissioned review of health inequalities research were clear.

A person's health behaviours, their physical environment, and socioeconomic factors, affect their health and wellbeing throughout their life. These factors – such as poor housing, pollution, poor diet, smoking, and lack of exercise –can combine to have a bigger effect on an individual, family, social group, or community. They lead to higher rates of a range of health conditions and, ultimately, lower life expectancy. Below we explore the various themes which help to explain health inequalities.

Ethnic minority groups have generally poorer health

Ethnic minority groups generally live in the most deprived areas of the UK. This is also true of people living with two or more health conditions, people with a disability, those experiencing homelessness, and those with drug or alcohol dependence.

Research by the Centre for Ageing Better shows that people reporting that they have poor health has been higher for ethnic minority groups than the white British population. For example, black Caribbean people and those from Pakistan and Bangladesh report poor health between 1.5 times and double the rate of white British people.

Cultural factors can influence health outcomes

The literature review looked at several studies focusing on how cultural factors can have an impact on an individual's health outcomes.

On the positive side, cultural factors, such as family support, sense of community, and religion, were shown to have a positive effect on the mental wellbeing of people from ethnic minority backgrounds.

However, cultural factors for ethnic minority groups can have an impact on health outcomes or be a barrier to accessing health and social care. Cultural or religious beliefs can lead to the misplaced use of traditional remedies. Differences in the presentation of symptoms can lead to misunderstandings, misdiagnosis, or incorrect referrals. Cultural differences may lead to a person not wanting to seek help if they have symptoms of cancer or a sexually transmitted infection[1].

In addition, a limited understanding of the English language may mean people do not understand health promotion materials and how to access the related services if translations or interpreters are not provided.

The role of the environment in a person's health

Environmental factors play an important role in a person's health outcomes.

A report[2] showed that Luton lacks green space – and the most deprived wards have less access to green spaces than wealthier parts of town.

A Friends of the Earth study on England's green spaces found a strong link between ethnicity and green space deprivation. It suggested that people from ethnic minorities are twice as likely as white people to live within areas with few green spaces.

In Milton Keynes, it has been identified[3] that 5.8% of deaths in adults over 30 are estimated to be due to poor air quality.

People who struggle to afford heating bills – those said to be in fuel poverty – are lower than the regional and national numbers in Milton Keynes but are increasing. This can make health conditions worse in the winter for people living in cold homes. People living in poverty may also be less likely to access the care they need or access it only when their condition has worsened.

1 Goff et al. 2020; Ehiwe et al. 2012
2 Joint Strategic Needs Assessment, Luton (2015)
3 Health Impact Assessment, Milton Keynes (2021)

Living and working conditions

Poor living and working conditions have a significant impact on a person's health outcomes. They are recognised as a critical problem within BLMK health reports.

The pandemic highlighted poor working conditions leading to health inequalities. The Race and Health Observatory 2022 review suggested ethnic minority healthcare workers had less access to personal protective equipment (PPE), with the pandemic having a more negative effect on their mental health.

Housing can play a very important role in widening inequalities. Many low-income families live in poor quality or overcrowded housing – some in temporary accommodation, disrupting children's well-being.

Children who live in poor housing[4] are more likely to suffer from poor health, have a longstanding illness or disability, dislike the area they live in, run away from home, be excluded from school, and leave school with no GCSEs. Poor housing leads to health risks such as respiratory illnesses, poor nutrition, depression, and anxiety.

Homelessness is a key driver of severe health inequalities. According to estimated data from Shelter, one in 66 people in Luton are classed as homeless, the worst figure for the entire UK outside of London. Milton Keynes was also ranked in the top 10 list of local highest rates areas for homelessness and rough sleeping.

There is a direct link between homelessness and access to health and social care services and management of long-term conditions. The Government's figure on the prevention and relief of homelessness in England shows that people from ethnic minority backgrounds are disproportionately affected by homelessness.

Health behaviours

Health behaviours, including physical activity, healthy food and social connections, can make a big difference to a person's overall health.

We know that access to affordable food is strongly influenced by income, so people living in poverty are estimated to need to use 45% of their available resources to afford healthy food, clearly not an option when there are so many competing demands. Whilst some physical activity opportunities are free to access there are barriers, such as transport and equipment, so inequalities exist here too.

A study[5] with Pakistani, Bangladeshi and white British mothers in Luton revealed that very few women consumed folic acid before conception, nor understood its benefits in preventing health problems from birth.

A different report found that African and South Asian women were more likely to endorse "using traditional remedies" for cancer and were more likely to report that they "pray about a symptom" than white British women. This may lead to accessing the NHS when their condition was at a later, harder to treat, stage.

4 Finney, & Harries (2013). Understanding ethnic inequalities in housing

5 Garcia (2018). Understanding the consumption of folic acid during preconception in Luton

A study[6] showed that COVID-19 had a significant impact on the health behaviours of ethnic minority groups especially during the lockdowns as they reported changes to behaviour such as low levels of physical activities. Hence, it is important to promote health awareness among ethnic minority groups to encourage healthy living.

Access to and uptake of health services

People affected by health inequalities had many barriers to accessing health services.

The biggest barrier for migrants to general practice registration is the inability to provide paperwork, with two out of five (39%) of registration refusals due to lack of ID.

Evidence shows that ethnic minority groups, including Gypsy, Roma and Traveller communities, and LGBT+ people face prejudice from GP surgery staff, including refusal to book an appointment. Several local studies also highlighted that patients were not always clear how to access urgent care services.

Inequalities in access to healthcare were experienced by the deaf community. According to Healthwatch Bedford Borough and Healthwatch Central Bedfordshire's 2021 Seen and Heard report, most study participants representing the deaf community found it challenging to access a GP appointment.

Social networks

Family and community networks were shown to be positive forces for ethnic minority groups. One study from the north of England showed participants preferred to live in neighbourhoods with people of the same ethnicity, even if it was a deprived area.

Another study showed that participants' spiritual and religious beliefs directly influenced their behaviour to maintain health and wellbeing.

A study[7] exploring relationships and faith argued that faith-based affiliations were significantly relevant for ethnic minority groups to pursue health and wellbeing.

6 Randhawa (2023) The impact of COVID-19 on the changes in health behaviours among Black, Asian and Minority Ethnic (BAME) communities in the United Kingdom (UK)

7 Ochieng, B. (2010).Spirituality as a mediating factor in black families' beliefs and experiences of health and wellbeing.

The pandemic and health inequalities

The COVID-19 pandemic disproportionally affected people from ethnic minority backgrounds.

Several studies showed that people from these groups have been at a much greater risk of contracting, being hospitalised, and dying from COVID-19.

Two studies, one for Bedford Borough and Central Bedfordshire[8], and another for Luton[9], revealed that participants acknowledged that inequalities experienced by different communities contributed to a more severe impact of COVID-19. Participants discussed how poor living conditions and overcrowded homes contributed to the transmission of the virus.

They said there was a great deal of community suspicion surrounding how ethnic minority groups were treated, compounded by a lack of confidence to complain.

A recent paper on vaccine hesitancy[10] among Luton's ethnic minority groups found a significant association between educational attainment and vaccine hesitancy. The most common reasons for low vaccine uptake among ethnic minority groups included lack of trust in the Government and vaccines, and concerns about vaccine side-effects. Public Health England statistics from 2021 showed that Luton had the third-lowest uptake of COVID-19 vaccine outside London in the UK.

8 Community Engagement & COVID-19 (2023), National Centre for Social Research
9 Ali, N., et al, (2021). Talk, Listen, Change (TLC) COVID-19.
10 Cook, et al (2022). Vaccination against COVID-19.

Listening to residents

The Denny Review commissioned studies by Healthwatch Bedford Borough, Healthwatch Central Bedfordshire, Healthwatch Luton and Healthwatch Milton Keynes, working in partnership with grassroots VCSE organisations where trusted relationships were held.

The lived experiences part of the review ensured that the voices of more than 2,000 local people who experienced health inequalities were heard through a range of surveys, case studies and detailed discovery interviews.

Gypsy, Roma and Traveller community

Despite growing evidence that Gypsies and Travellers are particularly disadvantaged in access to health care, there are very few studies to explore the reasons for this. Healthwatch Bedford Borough investigated the nature of the social disadvantage that the group experience. Nineteen members of this community were interviewed to explore both attitudes and structural reasons behind this health inequality.

People from the Gypsy, Roma and Traveller community told us:

- Almost all described **literacy as a barrier** to meaningful communication about their health or social care. About half said it was the most important barrier. One person described their feeling of shame in not being able to read or write.
- Only two or three people out of 19 interviewed felt literacy was not a barrier for them. The majority said they can't read text messages. Consequently, they often take these to the Gypsy and Traveller Liaison Officer for help.
- For some, the challenges regarding health literacy are so overwhelming that they feel lost in the system. Gypsies and Travellers say that they have described their issues to the NHS, and yet see nothing changing to address or improve these. One said: **"All of those forms, stupid asking."**
- The move to online services has resulted in more isolation and, as a result, the elderly and sick were unable to get help.
- The need for **videos and voice messages** was mentioned as a way of overcoming communication barriers. However, the lack of secure Wi-Fi on either of Bedford's local authority-run sites was an issue.
- The need to be understood was mentioned by people in the Gypsy and Traveller communities when asked that they wanted from the NHS.
- **Cultural understanding** was also mentioned by the majority of the Gypsies and Travellers who talked about communication barriers. They felt people were "clueless" at best and "scared of them" at worst.

Voices of Gypsy, Roma and Traveller people

One woman said:

> "Female doctors for pregnancy, smear tests. It's against Traveller ways for men to be involved."

When asked about the impact of being a Gypsy or Traveller on the treatment they receive, all but two felt that their cultural identity had a negative impact.

One said:

> "Every time they think I'm a Traveller I get treated real bad."

Another said:

> "They don't understand what I'm on about, I hate talking to them."

Women from migrant backgrounds

Women from migrant backgrounds have been found to be particularly at risk of health inequalities due to a combination of different factors, such as language skills and cultural differences. Healthwatch Bedford Borough spoke with women from West Africa, Bangladesh and Bulgaria.

Women from West Africa

A consistent theme was women's experiences of negative interactions, stereotyping, disrespect and cultural insensitivity. Interviews also explored the issue of female genital mutilation (FGM), a traditional cultural practice undertaken in some countries in West Africa. This is the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. Interviewers spoke with 15 black women from West Africa and women who have undergone FGM.

Women from West Africa said:

- There is a concern that the **stereotype** of the strong black woman may lead health professionals to discount expressions of pain, anxiety and vulnerability.
- Migrant women from Africa asked for **greater sensitivity** by healthcare providers. Half of this group said that being a black African woman had a negative impact on their care. They said they wanted to be spoken to nicely by healthcare professionals.
- FGM is a significant issue for this community. Women who had undergone FGM spoke of being subjected to hurtful comments, being asked questions such as "how did you get pregnant?" or "did your husband do this to you?"
- Negative experiences have meant that some women have avoided going to see their GPs, putting these women's health at further risk.
- **Language issues** and accent can become a barrier.

Voices of West African women

One woman said:

> "I hate how non-inclusive some services are. They will tell you what works for the average white female without even taking into consideration who you are [African]."

In contrast, one participant described a positive GP relationship:

> "My doctor and I have the same native language and it is great. It makes me feel heard and respected since we have the same cultural background."

Bangladeshi women

The Bangladeshi population in Bedford is a complex network of people who are the first, second and third generation of migrant families. Language skills, attitudes towards health, and attitudes about how to 'fit in' to mainstream society vary widely. Nine out of 10 Bangladeshi women could not read or write in either English or Bengali.

People from a Bangladeshi background are most likely not to speak English well, with Bangladeshi women five times more likely to speak no English at all.

Bangladeshi women said:

- They had a **high level of frustration**, because they are seen as being time-wasters with trivial reasons for approaching healthcare.
- All felt that they would get better treatment if they were white. They felt it was easy for them to be overlooked and not listened to.
- They were concerned about having to jump through hoops and described being talked down to by staff which, they say, results in unfair treatment.
- Some said they relied on a relative to help them access health services.
- All said they needed support from an interpreter.

Voices of Bangladeshi women

"Give us an appointment when needed not when about to die."

"The receptionist was very rude - she didn't listen and talked down to me."

"Sometimes it doesn't make sense. I have waited over 12 months to see someone. I had to do a blood test before the appointment. I had to book online and the next slot available was two weeks later. Waiting time in waiting room for completing blood tests is quick at the hospital. What was the point of me doing a blood test 12 months before I see someone at the hospital?"

Bulgarian women

Bulgarian people were part of a more recent pattern of migration following entry into the European Union in 2014. Bulgarians have high levels of cardiovascular disease, but cancer is below the European average. Mental health is generally not discussed in Bulgaria. Excess alcohol consumption and smoking are higher than the UK national average. Only one Bulgarian woman we spoke with could speak, read or write in English.

Bulgarian women said:

- Their health priorities included advice on stopping smoking, reducing alcohol intake, healthy eating and where to go to participate in activities.
- They were keen not to criticise, but they found **accessing care difficult.**
- All needed help from an interpreter. Seven out of the eight Bulgarian women were unaware of NHS messages, attributing this to the language barrier.
- Several Bulgarian women described **negative experiences** due to language difficulties. One spoke of a GP who refused to book an interpreter. Another had the phone put down on her.
- Three women mentioned poor communication, feeling stuck between departments and organisations that were not communicating with one another.
- Misunderstandings can arise from **cultural differences**. The women try to anticipate what would get a negative reaction from healthcare professionals.
- They thought that an understanding of the different culture and background of clients or patients should be a requirement for healthcare professionals.
- They were concerned about **understanding English etiquette** and would like to have group classes so that they can blend in.

Voices of Bulgarian women

"It can be interpreted wrongly, and you can have your child taken away. It is a difference in culture."

"Would not know where to go if there was an emergency."

LGBT+ people

Healthwatch Luton listened to 52 LGBT+ people, through survey, interview, email or phone call. LGBT stands for lesbian, gay, bisexual or transgender, and the plus sign stands for a range of other descriptions people may choose to use, such as queer or questioning, intersex or asexual.

LGBT+ people told us:

- Over half of respondents said staff and **staffing attitudes** were **more favourable** than in the past. They said staff were, caring, respectful, empathetic and responsive.
- The use of inclusive language was praised. This had the effect of a more honest dialogue between health and care clinicians and patients, with trusting relationships developed for ongoing care.
- Luton Sexual Health services/ iCaSH was praised as having **knowledgeable staff** and providing relevant information. Hospital support was 'great' according to a few respondents.
- General health prevention messages were clear but could be advertised more in more appropriate places, such as on digital forums and apps.
- Digital access to clinicians where available – worked best for a lot of responders, to support anonymity, when important, and allowed more flexible appointment times.
- For under-18s, information on gender identity was lacking, and waiting times for gender identity psychoanalysis were raised as concerns.
- Many felt they did **not have enough time with GPs**, particularly face-to-face, to discuss issues. Not seeing the same GP made it harder to have an open conversation. They felt there was a lack of support in referrals and hospital discharges.
- Residents said there was a lack of follow-ups or referrals from Children and Adult Mental Health Services (CAMHS), which resulted in increased hospital admissions.
- Some said health and care **staff continually got their gender wrong**, despite being corrected by the resident on more than one occasion. Residents said there was a lack of culturally or age appropriate LGBT+ groups.
- Some respondents had completely **stopped engaging** with health and care services, due to previous, distressing experiences. Sexual health information could be more widely available, for people of different age groups and cultures.
- A lack of cultural competency – both in terms of race and gender – was felt by some respondents, along with a lack of standardised sexual orientation and gender identity data collection.

Voices of LGBT+ people

"Being from the culture I am, being how I am is viewed so differently to how British people view it. But if you want to really understand how it makes us feel, then change how you present the world to us. My mental health has not ever been in crisis state, but I could have appreciated some more **culturally relevant support**.

"Telling my doctor from a different culture to mine, who has his own views on what I am and what I do – just makes for a very un-honest approach. I would never go to him for health advice and would only use online."

Male, Black Caribbean, bisexual

"I have had **many positive experiences** of health and care over the years and have to say I have felt limited stigmatisation in general health settings. Most I have encountered have accepted and not perceptibly judged or changed their level of care, from what I can tell.

"It is hard to discuss openly with my GP – so I tend to revert to the sexual health clinic for all manner of support, as I trust them. Training on **sensitivities of language** would be good – if you get the language right or try, you're half-way there. Some people just show disrespect with not even attempting to find the right words."

Male, white British, gay

"If you grow up seeing white women who don't reflect yourself, in every textbook or media image, **you learn to disengage very early on**...More culturally appropriate images have been seen on health messages more recently, but I wouldn't say it's the norm.

"We are constantly told Luton has more Asian people than other towns, and yet everything I still encounter is white – white, hetero-normative messaging – nothing that ever speaks to me as a young, questioning Pakistani."

Young Pakistani female, who identifies as queer / questioning

"There is more information than before – and that is great – but it's like it is all **written by people who don't really understand** what it is like to be LGBTQIA+. There is a lot even in the NHS guidelines that refer to all questioning or queer young people as 'transient' as though it's not for all of us something sustainable, or real.

"The support for young people with their mental wellbeing is so old-school and face-to-face – we need the online anonymous digital support to really support us... through what we are feeling."

Female, Catholic teenager, identifies as questioning

People who have experienced homelessness

YMCA Milton Keynes spoke with 47 young adults who live at its accommodation in the city centre. All the young people interviewed felt comfortable to share their information and views with a trusted professional in a familiar setting. YMCA staff clearly explained why they were collecting the information, and how the information would be used.

The residents interviewed were aged 18-35. 47% identified as female, 47% as male, while6% identified as 'other' including three transgender men.

The most common ethnicity was white British. Other ethnicities included black African, black British and Asian British. One in three interviewees (34%) identified as LGBT+ while two out of three did not.

Nearly half of respondents (49%) identified as having a disability, including mental health conditions. 13% declined to answer the question.

People who have experienced homelessness said:

- They had **difficulties getting GP appointments**, and some found receptionists to be rude in GP practices. Others said that GP appointments were often not long enough to deal with their issues.
- There was a varied experience of A&E services at hospital. Some said it was positive, while others said they had to wait a long time whilst experiencing significant pain.
- Mental health services are insufficient with long wait times experienced. One respondent said **services were inaccessible** due to their location. Others said they did not feel like they were being treated seriously.
- Those with mental health concerns said that the NHS often takes a 'medication-first' approach, rather than addressing the root cause.
- Those accessing social services said they felt social workers were sometimes not listening to them properly, or had acted against their interests or those of their family.

Voices of people who have experienced homelessness

"It's been eighteen months since I've been involved with my kids. I was deemed unfit because of my mental health. The social worker asked my partner questions about my mental health, but they never asked me. I feel I was written off because of it and I've been completely pushed out the picture. No effort to speak to me or to try and help me with my kids so I can have a relationship with them."

Male aged 31

"I've experienced a lot of racism [accessing the NHS]. One time, I said I had food poisoning and the paramedic said, "have you eaten chicken curry?" I think to myself, why is that? Is it because I'm Asian? He then asked me if I eat ham and I thought why are you [the paramedic] asking me this?"

British Asian female, aged 25

"You wait for ages, and then at the end of the wait, they say there's nothing they can do. It's the same across all the services. They make referrals to seem like they're doing something and it never goes anywhere."

Male, aged 19

People with a physical or learning disability, living in deprived areas

A survey was created and widely distributed by Healthwatch Central Bedfordshire which generated 1298 responses in October and November 2022. The questions sought to understand what specific services work well for individuals and which ones do not, and how those services could be improved.

People were asked what was most important to them in the way they are treated by healthcare professionals, and what the barriers are to accessing healthcare services. They were also asked how communications could be improved to access services more easily, and if they knew which preventative services were available to them.

People with a physical or learning disability said:

- The most common services which did not work well were GP services (29%), Children and Adolescent Mental Health Service (CAMHS) on 21%, and hospital on 18%.
- When asked what could be improved, residents particularly highlighted **easier access to appointments** and staff to be more helpful. The same improvements were desired for hospital services.
- A need for interpreters in hospitals was highlighted by 26% of respondents. A similar proportion said more appointments with a Disability Champion would be beneficial. This suggests **disability awareness is an issue** within hospital services.
- The way residents with disabilities are listened to was highlighted as a key issue. Three out of 10 respondents said they wanted to be listened to, and a quarter wanted to be involved in decision-making. Being **treated equally** was highlighted by one in every five survey respondents.
- Respondents viewed the biggest barriers to accessing services as the difficulty in getting appointments, waiting lists, staff shortages, **no disabled access** and a lack of interpreters.
- **Communication** was a key area for improvement. A majority wanted hearing loops installed, longer appointments and interpreter services. They also wanted their individual needs to be understood.
- Many survey respondents were positive about participating in activities to **prevent health problems**. Exercise and active lifestyle choices were desired by people with disabilities, as well as screening services.

Voices of residents experiencing physical or learning disabilities

"My GP seems to rely on 111 to screen patients and arrange appointments. Also, I am deaf and they don't seem to understand that a phone appointment is useless, I need face to face but cannot get this."

"My husband and I have repeatedly been let down by social services. Hospital communication needs significant improvement for those with dementia. There needs to be closer communication between professionals, for people who live in Central Beds but whose GP is in Buckinghamshire and whose nearest hospital is Luton & Dunstable, or other cross-county issues."

Case study: A mother's experience of accessing healthcare with her autistic son

Mrs C, from Luton, is a care-giver to her teenage son who has autism and learning disabilities.

Mrs C told us that getting appointments with a GP for her son was usually difficult. She often found that they had to wait for a long time in the surgery for an appointment to begin, which her son, who is sensitive to loud noises, beeping sounds or unexpected movement, finds stressful. She also said that healthcare workers were often not well-informed about her son's medical history, and might be unfamiliar with the variety of behaviour autistic people can display.

For example, when Mrs C visited a doctor's surgery with her son, the receptionist insisted he wore a mask, even when she explained this was difficult for her son. She then put it on her son, only for him to rip it off.

She said: "For this reason I do not go to appointments alone with my son, I go with one of his brothers or anyone I can find. He is such a body builder and things can go horribly wrong."

Mrs C and her son have had positive experiences, such as when a healthcare worker took time with her son, going at his pace when taking measurements. She also praised the annual health checks to which her son is entitled.

Mrs C cited a major challenge as the lack of joined-up care, where her son is passed between different people, rather than a more consistent co-ordinated approach being taken.

In addition, she said that simple changes can make a big difference. Providing photos of the healthcare setting her son will attend can help him to prepare and result in him being more calm and comfortable.

Mrs C was dissatisfied with information from healthcare providers about the guidelines for her son's health needs. She thinks information could be more tailored, such as for non-verbal individuals. She emphasised the importance of training for parents, who can play a critical role in supporting their child's health needs – with people sharing their lived experience of providing care particularly beneficial.

Insights and themes

In the many conversations and responses from residents, common insights and themes were raised. Here we summarise the key areas which were consistently brought up by residents. Some of the insights are linked, or can combine, to create a greater, negative impact for those who experience health inequalities.

Accessing services

Gaining access to services – whether that is with a GP, a hospital, or a different healthcare setting – was consistently raised as an issue by residents, such as in Healthwatch Milton Keynes' inequalities survey and interviews.

For GP services, simply getting an appointment was found to be difficult by many. When residents managed to get an appointment, this was sometimes not face-to-face when that was a clear, and sometimes necessary, preference. In addition, the length of appointments was felt to be too short by many to get to the heart of the matter.

At each stage, residents spoke of difficulties convincing someone that they needed help, or that their need was sufficiently serious. For example, people spoke of having to convince a receptionist they needed to see a GP, or convincing a GP that they needed a referral.

> "I can't get an appointment, when I do get through on the phone, they say you have to access the online portal. When I say I can't, they hang up on me."

Some residents said that appointment times were not available at the times when they could attend, creating a barrier to health services.

People with physical disabilities found that having to attend A&E or urgent care was particularly difficult because the long wait times could be physically impossible for them. This was also noted as an issue for people with mental ill health or neurodiverse conditions.

Some felt doubly penalised because they tended to avoid contacting the GP due to worries about staff attitudes towards their particular characteristic, and so their needs were more acute by the time they were seen.

> "I always feel rushed which makes me nervous and forget what I want to say...long waits and impatient staff over the years also increase my nervousness and inability to approach health and care services in a relaxed manner."

Digital methods of accessing services caused barriers for a range of different people. This includes those with low levels of literacy, people who aren't fluent in English, and people who can't afford an internet connection, or don't have a smartphone.

Finally, while there are many VCSE groups offering support, there is no single place to find this information, or it is inaccessible. This means there is often a disconnect between those offering support and people who need it most.

Literacy and interpreters

Literacy was raised as an issue for some people, both from migrant backgrounds, and members of the Gypsy, Roma and Traveller community, for whom literacy is not a traditional part of their culture.

Migrant women are more likely to be illiterate than their male counterparts. They therefore find it difficult to access health information and successfully navigate the health and care system. This language and literacy barrier is a significant driver of health inequality.

Residents spoke of the need to access services to reduce the barriers they face. There is a need for resident to know about what is available to help them.

The need for **interpreters** was a consistent theme from people from migrant backgrounds. Most migrant women we spoke with could not speak English, which presented a barrier to them getting the help they needed. Some said they asked friends or family to help them, but again they tried not to do this too often because they did not want to be a burden. This in turn could lead to a delay in getting help, and their condition getting worse.

Those who needed an interpreter struggled to find one. And if they did, this greatly reduced the appointments they could attend with an interpreter, due to their availability. However, even with interpreters some said they didn't understand what was being explained to them – suggesting that a visual approach using photos, diagrams or pictures could help.

For members of the Gypsy, Roma and Traveller community, audio messages would be welcome.

> "If English isn't your first language, you may have a male family member take you to the appointment but how can you feel comfortable if the appointment was to talk about a female thing, a personal female issue?"

Cultural understanding and personalisation

The residents we spoke with often felt that there was a simple lack of understanding of their culture, background or characteristics. While this might be unintentional, it can make a person feel that a service is not for them – and that racism, sexism or homophobia might be the root cause. This can lead to them being much more reluctant to access health and care services.

This can play out in a range of different ways. It could mean that a person is judged by stereotypes, rather than who they are as an individual, or their symptoms downplayed or disregarded. It could mean that the way in which a person speaks is misinterpreted, due to cultural difference. Or it could be that parts of a person's religious or cultural backgrounds which are a vital part of their understanding and approach to health matters are not taken into account.

For LGBT+ people, a common issue was referring to them by the wrong name, gender, or pronouns, which leads to a sense that they are not being treated fairly or equally.

This lack of understanding can have a damaging impact for the people affected – but if an understanding is demonstrated, or a willing to adjust, this is welcomed.

Seeing the whole person

The need to be seen as an individual was regularly cited by residents as something they wanted to see from healthcare professionals. People felt that services were not linked together, so that they had to repeat the same facts again and again.

In addition, residents felt that services were not 'person-centred'. In essence, this comes down to services being delivered in a way that makes sense to organisations, but not to the individual. This often meant that services feel inflexible, and could send a person down a path which was not right for them.

People from ethnic minority groups said they often felt health professionals didn't see them as a whole person. They also had a strong sense that they weren't being cared for because appointments were so rushed.

Those with strong religious beliefs said they felt there was no place for their faith to be part of discussions around care and treatment. Whether discussions were around lifestyle or around medication, they felt that their particular belief system was seen as separate to themselves, their illness or their recovery. They felt their beliefs should be integrated into the conversation to support more appropriate clinical care.

People with mental ill health felt that a lot of the care or treatment they received was done to them, not with them, and that they were not involved in discussions about the benefits, or side effects, of available treatments. They shared that they often felt 'fobbed off' with pills on the first attempt to talk about their mental health. Those who had an existing diagnosis said they were worried that if they talked about what they were experiencing, they would be sectioned.

Appropriate communication

Issues with communication were many and varied – and almost all respondents had some sense that they were not being communicated with properly.

For example, one deaf person said they were spoken to by a healthcare professional wearing a mask, which made it impossible for them to understand what was being said. More generally, it was often felt that front-line staff made presumptions about a person based on their individual characteristics, such as skin colour, accent, or how they dressed.

Communication by healthcare professionals was often too technical or full or jargon to be understood. This could leave a patient feeling overwhelmed with information, and unable to make informed choices.

Information produced by NHS organisations was often off-putting for people from some groups, such as LGBT+ people. The information might be written in a way that suggested the author did not understand their perspective, or the images were not inclusive.

Sometimes the type of communication was not right, with a reliance on more traditional forms of communication, like letters, when text messages, audio messages, or better use of video might open up access to people from a range of different backgrounds.

Case study:
Ms F – a generally positive experience

Ms F (using pronouns they/them) has, in general, had a positive experience of using healthcare services. They did not say what their specific needs were, but said healthcare professionals adapted to suit those needs.

Ms F said, however, that there is a lack of flexibility in scheduling appointment times. They said the "ability to reschedule is very difficult and rigid" and the next appointment "can be weeks away."

Furthermore, they sometimes need additional support to access the venue of the service they are using, which isn't always offered.

However, within the service, adjustments are usually made in an appropriate way, and staff are mostly friendly and helpful.

Ms F welcomed text messages with information about appointments but said this was inconsistent across different services. In addition, they said that their patient records were shared across the GP and hospital, but this was not the case for other, smaller services.

Overall, Ms F was happy with the services, but felt that the health service could be more joined up, with better customer service, and improved flexibility on appointment times.

Recommendations

Our recommendations fit within four groups. These are **access, communication, representation** and **cultural competency**. They are grouped in two time-frames. The first is short-term changes which can be actioned over the next one to two years.

These changes will allow residents to see that things are changing for the better. The second category of recommendations are longer-term and will change how the health and care system operates in a deeper and more fundamental way. It's important to note that some work has already taken place in some of the areas outlined in the recommendations – but greater focus and momentum is essential.

How we developed the recommendations

Overall it is the clear ambition of this report to make recommendations which, when taken together, spur system leaders to respond radically in designing and delivering their approach to health inequalities.

The recommendations have been developed by the Denny Review Steering Group based on the published evidence and the views of residents.

Further work is required with community pharmacists, dentists, optometrists, NHS Trusts and local authorities and the VCSE sector to determine how the recommendations can be implemented and performance monitored, and to define the crucial role provider collaboratives can play. These organisations will need to come together to determine whether the recommendations are delivering the impact called for by residents and healthcare professionals.

Short-term change

Recommendations that can be implemented in the shorter term, which will help to make an immediate difference to the experience of residents over the next one to two years.

Insight area	Recommendation
Access	Contracts for new products and services should rigorously apply the Accessible Information Standards and the Equality Act so that they meet the needs of all residents and staff members, for example when purchasing personal protective equipment (PPE). This includes ensuring that residents are asked about or offered information in a format or language that they can understand. Consideration should be made to help prevent residents being excluded from services due to barriers which include a lack of access to digital technology.
	An urgent review of all health and care premises should be undertaken to ensure disability access is always available.
	Hearing loops should be installed across all healthcare establishments and staff should be provided with training to ensure they are always functional.
	Hospital trusts and primary care should undertake a review of what, if any, interpreter and translation services are available and accessible to ensure patient needs are being met.
	GP practices should review their procedures to stop residents being wrongly stopped from registering, potentially denying them access to essential health services. Practices must ensure they meet Primary Medical Care Policy and Guidance, and that national policy is uniformly and rigorously applied.

Insight area	Recommendation
Communications	Residents and partners to come together to co-develop a communications campaign to support people to explain how the health and care system works, and how to navigate it, with a particular focus on supporting minority groups. This campaign should include regular updates on the implementation of the Denny Review, and, where relevant, have a gender focus too for specific men's/women's issues highlighted.
	Urgent review of all communications and marketing materials to ensure that imagery and language is culturally appropriate and reflects the different communities in BLMK.
	Collaborate to implement a universal translation service for BLMK that provides consistency across all NHS provider organisations. This should be achieved by undertaking an urgent review of all translation services provided in BLMK's health and care sector to ensure it complies with Accessible Information Standards. This should mean that interpreters are always available, that there is consistency across primary and secondary care services, and that British Sign Language (BSL) interpreters are included in the list of available languages.

Insight area	Recommendation
Representation	Support GP practices to ensure that Patient Participation Groups, as required within contracts, are in place and receive sufficient investment.
	BLMK Integrated Care System should set out how its future engagement work is shared, to avoid duplication of effort and maximise impact.
	Training for health and care professionals and those people involved in community connector roles in Quality Improvement (QI) and co-production. This will help to embed a more person-centred approach, so that residents' needs are at the heart of any solution.
	Support the healthcare system to be more resilient for future pandemics. Consider the impact they can have on the workforce, specifically people from ethnic minority backgrounds. Within this, look at how PPE is distributed to meet the needs of a diverse health and care workforce.
	Senior leadership mentoring scheme introduced within NHS organisations for people from ethnic minority backgrounds to help improve diversity management across the ICS. Encourage greater diversity within management, and greater diversity on interview panels.
Cultural competency	Training rolled out to all health and care settings to support with language, and understanding the needs of residents, including different ethnicities, those with physical and learning disabilities, and LGBT+ people. This will help to address perceptions of cultural bias / racism which was a consistent theme within community engagement and can build on current patient participation.
	Greater investment in services that are working well, such as local sexual health services.

Long-term change

Recommendations which make larger, more fundamental changes to how healthcare is delivered, which residents will see the effect of over the next three to five years.

Insight area	Recommendation
Access	Consider extending the service hours available in primary care to evenings and weekends for those unable to attend day-time appointments. Also include access to female-only clinics to support people from different faiths and cultures, and victims of male violence.
	Ensure that residents who would prefer to access some healthcare services anonymously are able to do so. This could be done, for example, through more services, or a greater proportion of them, being provided digitally.
	Work with the VCSE to fund Access Champions to support people who are unsure how to navigate health and care services or have additional needs to access appointments, or other services to support their health and wellbeing.
	Establish an end-to-end service for long COVID.
Communication	Based on the findings of the review of interpretation services, ensure that there is a consistent service across health and care and that translated materials are available in line with legal duties.
Representation	Improve integration of housing, hospitals and mental health support in homeless shelters.
	1 in 4 black men will get **prostate cancer** in their lifetime. Black men are more likely to get prostate cancer than other men, who have a 1 in 8 chance of getting prostate cancer, according to Prostate Cancer UK. The ICB should work with **researchers** to better understand the extent of this issue in BLMK and the reasons behind it. Furthermore, that the ICB develop a programme of engagement with men in general regarding their personal health and co-produce with residents communications activity focused on specific support available for male health.

Insight area	Recommendation
Cultural competency	Develop an Asset Based Community Development (ABCD) approach to engaging with local communities to drive grassroots change and represent their views in service development. ABCD is a way of local people taking the lead, and developing solutions for themselves, supported by statutory organisations, such as local councils. This would be achieved by ring-fenced investment being provided to VCSE and Healthwatch organisations to continue to build on the dialogue and trusted relationships developed in this review and lead to continuous improvements. Funding these organisations would enable them to proactively co-produce solutions with residents.
	Co-produce solutions with people from different backgrounds, including people with learning disabilities, young people affected by mental ill health and autism, and refugees, to adjust health services and the spaces in which they are delivered to make them more appropriate and inclusive.
	Co-produce services and training resources with transgender people, people from different ethnic minorities and cultures or faiths to increase awareness of individual needs, so that health and care professionals feel confident and empowered to better support patients. This will better support people when receiving diagnoses or delivering care for their specific needs.
	Develop an education programme for refugees to develop skills and independence to support them in understanding the health system and navigating it. This should also educate refugees on rights available to them, such as taking time off work to support family members and access to health and care.
	Undertake further research to understand the barriers that ethnic minorities including Gypsy, Roma, Travellers, face. Work with residents as part of an Asset Based Community Development approach to develop solutions for greater equality.
	Develop more service offers that involve going into communities, where people are most comfortable, such as pop-up centres, building on the successful approaches adopted through the COVID vaccination programme.
	Encourage health and care professionals to add a 'listening to patients' section to every training event to ensure lived experiences of local people are shared and professionals are given the opportunity to identify solutions to improve the quality of services / experiences.
	Review what is currently in place to provide healthcare advice, guidance and signposting information to residents. Develop a consistent approach so that people can get access to information about the services they need.

Embedding the recommendations through Quality Improvement

Our recommendations aim to tackle deep, longstanding issues, which are often complex.

To succeed, this requires a Quality Improvement (QI) approach, which involves staff and service users to explore the issues, unpick them, and develop services in a more person-centred way.

This means giving residents a much stronger voice, and thinking about what the ultimate goal is, rather than how organisations are currently run. Ultimately, residents need to feel that services have taken into account what they want, how they feel, and what is logical for them. It necessarily means being more flexible, and not rushing to judgement about what a person does or does not need.

By focusing on what residents and staff who work within services areas think, this should help to make inclusion something that is inherent within health and care services, part of their DNA.

Equality Delivery System (2022)

While much of the focus of our review has been on residents, we cannot forget staff members, who often live in the communities they serve.

The Equality Delivery System (EDS) helps NHS systems and organisations improve the services they provide while supporting better working environments, free of discrimination.

The main purpose of the EDS is to help the NHS, in discussion with local partners and local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010, such as sex, disability or race.

Therefore, part of the way we can reduce health inequalities is through ensuring the EDS is rigorously applied and appropriately scrutinised. There is an opportunity to apply the EDS when health and care providers procure new products and services, to create a more fair and equal health service for all, including NHS staff.

Accessible Information Standard

A big theme from residents was around accessibility. One of the ways better accessibility can be delivered is through the Accessible Information Standard. All organisations that provide NHS care or publicly-funded adult social care are legally required to follow the Standard. It sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Financial investment

This review has not put a price tag on its findings and recommendations. However, to deliver the generational change required to level the playing field, significant investment will be required to support the delivery of the above recommendations.

While it is recognised that considerable investment is needed across BLMK in its entirety, the Denny Review recommends that funding be prioritised in areas where there is a greater prevalence of known health inequalities.

Prioritisation of funding would support the Integrated Care System's prevention agenda. This is because data shows that areas with large populations of black and south Asian residents have greater numbers of people who contract diseases including type 2 diabetes, sickle cell anaemia, thalassaemia, long COVID, heart disease, cancer, as well as higher levels of infant and maternal mortality.

The quality of services is unequal in terms of availability and delivery. Therefore, spending needs to be prioritised to address historical inequalities so the past is not carried into the future. For example, more needs to be spent on preventing type 2 diabetes because this preventable disease significantly disproportionately affects Black and Asian people.

Conclusion

by Reverend Lloyd Denny

COVID-19 as a global emergency is now over. However, the long-term effects of the pandemic cast an uncertain shadow into the future. The inequalities identified in this report in terms of the disease and death and take-up of the COVID-19 vaccine were exacerbated due to a lack of trust in officialdom and in "the system".

To build trust, the challenge is to demystify decision-making processes, so they can be better understood. Furthermore, we need to make sure that there is cultural competency and diversity at senior levels of organisations. This is particularly important in the public sector.

Building trust will take time. Bedfordshire, Luton and Milton Keynes ICB, and all its system partners, need to acknowledge this and find ways to ensure that health inequalities for people from different communities or with different personal characteristics are mitigated against. Reducing health inequalities needs to become part of everyday business.

Leadership is the key to change. This review was commissioned to draw out recommendations and support system leaders to make evidence-based decisions. I have participated in NHS-wide events, discussions and meetings in connection with this review and have been assured that the review has national interest.

This report has focused on the experiences of the public as recipients of NHS services and care. The evidence shows there is clear disparity in the quality of care received and outcome.

I have seen for myself the benefits of good health and social care. The relief, joy and gratitude patients and their families have when a baby is successfully delivered at a hospital. The tears of joy when a life-saving medical procedure goes well. Sadly, good outcomes are not universal across the system. Sometimes this disparity is only a postcode away.

I hope that those in leadership positions in the health and social care system will recognise the scale of the change needed, rise to the challenge for the public wants it, and work with communities to bring about equality for all in the most basic of human need. A failure of leadership created some of the health inequalities faced by the Windrush generation. Therefore, we need to show, 75 years on, that we have learned.

These recommendations must be acted upon to help improve the healthcare system and to build residents' trust in it. If implementation of specific recommendations doesn't happen, the reasons why need to be clearly communicated.

Conclusion *continued*

Health inequality and inequity

There are many kinds of health inequality and several ways in which the term is used. Various definitions exist[11] but broadly speaking, health inequalities can be defined as:

- The avoidable and unfair differences in health across different groups of people
- Differences and biases in the access, quality and experiences of care
- The wider determinants of health, such as housing and income.

A further definition of health inequality by Lord Victor Adebowale, Chair, NHS Confederation: "Inequality is the way of the world; inequity is what we do with the way of the world."

Also from Lord Adebowale: "The NHS was not designed for inequality or inequity; it was designed to eradicate it. It should shame us that we are heading in the wrong direction. We have to make this core business. There isn't a plan B for the NHS."

We must heed these words, and those of residents and NHS staff, to make the changes we need, and demonstrate that serious action is being taken.

11 King's Fund (2020): What are health inequalities?

Steering Group Members

Reverend Lloyd Denny DL
Chair

Liz Cox
Associate Director of Finance - Strategy, Planning and Performance at BLMK ICB

Diana Blackmun
Chief Executive, Healthwatch Central Bedfordshire

Chimeme Egtubah
Service Manager, Health Inequalities and Communities, Luton Council

Emma Freda
Deputy Chief Executive, Healthwatch Bedford Borough

Colin Moone
Director, Housing, Luton Council

Lucy Nicholson
Chief Executive, Healthwatch Luton

Elizabeth Learoyd
Managing Director, Engaging Communities Solutions

Maxine Taffetani
Chief Executive, Healthwatch Milton Keynes

Nicola Kay
ICS Programme Director, BLMK ICB (until July 2022)

Paul Calaminus
Chief Executive, East London NHS Foundation Trust

Laura MacSweeney
Business Support Manager, BLMK ICB

Sally Cartwright
Director of Public Health, Luton Council

Michael Keating
Project Manager, East London NHS Foundation Trust

Steering Group Members *continued*

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Professor of Diversity in Public Health at the University of Bedfordshire and Director, Institute for Health Research

Julia Robson
Inequalities Programme Lead for BLMK, East London NHS Foundation Trust

Celia Shohet
Assistant Director – Public Health for Central Bedfordshire, Bedford Borough and Milton Keynes

Michelle Summers
Associate Director – Communications, BLMK ICB

Helen Terry
Chief Executive, Healthwatch Bedford Borough (until December 2022) – Elizabeth Learoyd and Emma Freda have represented Healthwatch Bedford Borough since the beginning of 2023.

Thank you

We would like to thank all of the residents from across Bedfordshire, Luton and Milton Keynes people who gave their views to the Denny Review.

We also want to thank all of the organisations who have contributed to the Denny Review:

Healthwatch Bedford Borough

Healthwatch Central Bedfordshire

Healthwatch Luton

Healthwatch Milton Keynes

YMCA Milton Keynes

Community Action: MK

Disability Resource Centre

ACCM (UK)

Queen's Park Community Organisation (QPCO)

Bedford Borough Council's Gypsy and Traveller Liaison Officer, Sharon Wilson

Community Dental Services

Penrose Synergy Ambassadors

Pride in Luton

All others who participated and contributed.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board of Directors**	**Date: 02 November 2023**
Report Title	**Serious Incident Report**	**Agenda Item Number: 8**
Lead Director	**Dr Ian Reckless, Medical Director and Deputy Chief Executive** **Kate Jarman, Director of Corporate Affairs and Communications**	
Report Author	**Tina Worth, Head of Patient Safety & Legal Services**	

Introduction	**Assurance Item**		
Key Messages to Note	This report provides a monthly overview of management processes/systems in relation to serious incidents in the Trust.		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Review** [x]

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

Report History	Serious Incident Review Group
Next Steps	Monthly incident/SI overarching issues reporting
Appendices/Attachments	Trends in graphical format

Serious Incident Report for September and October 2023 (up to 24/10/23)

There were nine new SIs reported on STEIS in September and October (to 24/10/2023). See table below.

Reference	Division	Category	Summary	Immediate Actions
2023/17751		Medication incident	Patient had a hospital admission and was prescribed two weeks of medication on discharge (as per hospital policy), however there was a note on the system to only prescribe a week of medication as patient also received medication in the community. Patient found unresponsive at home having with cause of death established as opiate toxicity.	Internal Serious Incident investigation. Coronial inquest. The Trust has been issued with a Regulation 28 Report (at the time of writing, not yet formally received) with the recommendation that an electronic flag is added to the e-prescribing system to notify prescribers of alerts requiring deviance from standard practice or other action.
2023/18362		Medication incident	Gentamicin administration error	Internal Serious Incident investigation. Quality improvement programme for medication administration and prescribing
2023/18364	Medicine	Unexpected death post elective duodenal polypectomy *(the duodenum is the first part of the small bowel, and a polypectomy is the removal of polyps).*	Concerns identified in the preliminary investigation around escalation when patient deteriorated; and the care pathway for patients requiring overnight admission following a polypectomy	Internal Serious Incident (SI) investigation ongoing.
2023/18365	Emergency Medicine (ED)	Traumatic finger injury	A young child trapped their fingers in the hinge-side of the door whilst using the toilet accompanied by a parent in the adult Emergency Department. This	Reported to the Health and Safety Executive via RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences.

			resulted in serious injury to the child.	Estates carrying out further risk assessments for door guards (already in use in paediatric areas).
2023/19155	Women's Health	Inter Uterine Death	Baby at 40 weeks and one day gestation died during labour.	Referral to the Healthcare Safety Investigation Branch for independent external investigation.
2023/19156	Women's' Health	Baby born in poor health	Baby at 38 weeks and five days gestation delivered by emergency c-section. Baby born in poor health, requiring therapeutic cooling at a tertiary centre.	Referral to the Healthcare Safety Investigation Branch for independent external investigation.
2023/19157	Surgery	MSSA bacteraemia	Methicillin Sensitive Staphylococcus Aureus bacteraemia infection identified	Internal Serious Incident (SI investigation.
2023/19518	Medicine	Aspiration of food/ medicine *(Please note, this has been previously reported to the Board as part of a review of three incidents involving choking or aspiration – this is one of the three Serious Incidents investigated and not a new Serious Incident).*	Patient found by family to have food and medication residue in his mouth (whilst an inpatient). Patient subsequently treated for aspiration pneumonia, deteriorated and sadly died.	Internal Serious Incident (SI investigation. Eating and Drinking at Risk Policy and practice documents developed with external partners (CNWL)

Trends and Concerns

Incidents are reviewed to look for any trends or issues of concern that require escalation outside the investigation process (e.g. into a quality improvement programme or for potential external review).

The following issues have been identified, with action summarised against each in the table below:

Issue	Action
Pressure ulcers	Continuing focus and quality improvement programme with positive results in reducing incidents and the early identification of pressure damage. This work will remain a focus (in line with our Quality Priorities) throughout the year.

Violence and abuse	Reducing and preventing violence and abuse remains a key area of focus and continuing action. A number of incidents relate to patients with complex mental health needs, and the provision of care and support that is not medical – i.e. patients who remain in hospital awaiting a social care or mental health placement. This has been escalated through the Integrated Care Board and reported to the Care Quality Commission.
Medication errors	This is part of a Trust-wide quality improvement programme to improve medicines safety and reduce the likelihood of administration or prescribing errors or omissions.
Discharge processes	This is part of a Trust-wide quality improvement programme to improve discharge processes, working with partners organisations including CNWL (community services provider)
Staffing pressures	A new electronic staffing tool is now in use to RAG rate staffing in every area, reviewed several times a day. This enables the senior nursing and site management team to identify areas at risk in terms of patient acuity and/or staffing levels and skill mix and take immediate mitigating action to optimise staffing levels across wards and departments.

Addressing Overdue Radar Incidents

There are currently a higher number of incidents that are overdue further investigation/ action or closure than usual (this excludes serious incidents that are escalated, managed and tracked separately).

Overdue incidents are incidents where opportunities for learning and action are delayed because action is not being taken by the investigator.

This is in part due to Radar system issues (for example, the system allocates the incident to an investigator who may be away from work); and the capacity/ time available to clinicians and other staff to complete investigation work.

The Patient Safety, Quality Improvement, Risk and Assurance teams are holding dedicated days in October and November to review this backlog with a view to reducing the number via a supportive triage and escalation process.

Moving to the Patient Safety Incident Response Framework

The Trust continues with a pilot version of the Patient Safety Incident Response Framework (PSIRF) as recruitment to posts in the Patient Safety, Quality Improvement and Risk and Assurance teams is finalised.

Currently the triage process covers all patient safety-related incidents for Ward 23, Ward 1 and Imaging. The triage panel occurs daily from 8amwith all incidents from the previous reviewed and allocated one of four levels:

- Level 1 – Patient safety incident investigation (PSII investigation) e.g., never events, mandated national requirements like a maternal death & Trust specific set priorities like sepsis.
- Level 2 – Patient safety response (learning) and will include after action reviews (AARs) and MDT reviews.
- Level 3 – Service incident review (improvement) & those incidents linked to ongoing quality improvement work e.g. Care Review and Learning Group for pressure ulcers
- Level 4 – Those where more information is required.

All community pressure ulcers are closed on Radar after triage. All new/ hospital acquired pressure ulcers and falls have been assigned to Corporate Nursing to review and link with the ongoing quality improvement and harm prevention work in these two areas

Shared Learning from Incidents

Learning generated from incidents and during discussions at Serious Incident Review Group meetings are shared via the 'Spotlight on Safety' message in the weekly CEO Newsletter.

During October 2023, nine individual learning/reflection/discussion or 'what's trending' points have been shared with the following themes:

- As we move towards the new Patient Safety Incident Response Framework, and the creation of a safe, learning culture at MKUH, it is essential that we all engage in learning events following patient safety incidents. Multidisciplinary Team (MDT) learning events such as after-action reviews or MDT round table reviews, are designed to help teams come together in a safe, supportive environment to focus on the 'real work' by those who do it, in order to make real improvements to patient safety.
- Recent incidents have been a good reminder of how important documentation can be. In the eyes of the law, if it's not recorded- it didn't happen!
- Getting it right from the start at the front door is essential for ensuring patients remain safe and have all the appropriate care and treatment they need. This can include assessments, prescribing and interventions.
- The importance of checking cannula/infusion/drain sites, noticing areas of concerns, completing the VIP score and escalating for review if necessary. It is important to hand over findings to colleagues on the next shift.
- That it's not uncommon for patients, or their relatives, to phone for advice or attend assessment areas on multiple occasions with similar concerns or symptoms. It can sometimes be easy to miss if patients are masking other, more serious, conditions.

- It is important all of us are vigilant when caring for our patients holistically. Whilst it is necessary to focus on and treat the clinical problem with the greatest need, we must NOT forget other underlying medical problems which may also need considering or treating.

- For a pop-up that appears when a patient has a NEWS2 of 5 or mor., it is the responsibility of the registered members of staff providing care for that patient at the time to action this pop-up and complete the sepsis screening tool.

- How effective good-quality safety netting can be when discharging patients' home. Empowering our patients with the knowledge of what signs and symptoms to look out for, and when to seek further medical help can be life-saving

- The importance of following the escalation pathways for clinical concerns and deteriorating patients.

HM Coronial Inquests

Inquests of note

Forthcoming Inquest 1:

A concern was raised by family that the patient had been found with food in his mouth. He developed aspiration pneumonia and was treated with antibiotics, fluids, oxygen and pain relief. However, despite best efforts, sadly passed away. Cause of death was reported as follows:
1a) Aspiration pneumonia
1b) Chronic dysphagia
II) Learning disability, Type 2 Diabetes

There has been collaborative working with CNWL to draft an Eating and Drinking at Risk policy and supporting information; and the implementation of the Oliver McGowan training for all staff.

Forthcoming Inquest 2:

Patient suffered a fall at home and sustained a right knee laceration and left thigh haematoma. She underwent surgery to repair the laceration and the haematoma was managed conservatively. Patient deteriorated and sadly died.
Cause of death was reported to as follows:
1a) Sepsis due to infective right knee
1b) laceration of right knee due to fall

This inquest has been adjourned as care issues were identified during the course of inquest preparation (and do not appear to have been identified through the usual processes). The Trust flagged these issues to HM Coroner as soon as they were discovered – resulting in the adjournment to enable all parties to the inquest adequate time to prepare. The inquest will be heard in November.

Forthcoming Inquest 3:

Patient underwent an endoscopic retrograde cholangio pancreatography (ERCP) to remove two gall stones. Following the ERCP was admitted overnight for observation. A computerised tomography (CT) scan showed a duodenal perforation. He was transferred to the Intensive care Unit (ICU) where he continued to deteriorate despite receiving maximum treatment. The medical cause of death has been given as:
1.a. Multi-organ Failure
1.b. Duodenal perforation
1.c. endoscopic retrograde cholangio pancreatography
2. Ischaemic heart disease

Forthcoming Inquest 4:

Patient underwent an endoscopic duodenal polypectomy. He remained in hospital for post-surgical care, became unwell at the hospital and subsequently sadly died. A post-mortem examination was performed, and the medical cause of death has been given as:
1a) Peritonitis
b) Perforated duodenum
c) Endoscopic duodenal polypectomy

In recent months there have been a number of post endoscopic procedural cases reported to HM Coroner. The Associate Medical Director is drafting a thematic review of these cases, including analysis of a recent audit data collection. This will be shared with HM Coroner in advance of the inquests.

Forthcoming Inquest 5:

Death in custody (pre-inquest review hearing in December).

Regulation 28 Reports (Preventing Future Deaths)

The following is extracted from the Regulation 28 Report following the inquest into the death of HS. The Regulation 28 Report was received by the Trust on 4th August 2023.

On 03 April 2023 I commenced an investigation into the death of HS aged 77. The investigation concluded at the end of the inquest on 20 July 2023. The conclusion of the inquest was that: 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 deceased suffered a stroke on 15th February 2023 and was admitted to Milton Keynes University hospital and transferred to John Radcliffe hospital for a thrombectomy and was repatriated back to Milton Keynes on the 20th February 2023, he underwent a PEG insertion on the 23rd March 2023 caused a large haemoperitoneum that was not recognised at the time. His condition deteriorated and he died on 26th March 2023.

During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The matters of concern are as follows: 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 responded in full to HM Coroner on 6 September 2023.

External Inspections

The Health and Safety Executive will be inspecting the Trust for a week in January 2023, with a focussed inspection on action taken to prevent violence and aggression and managing musculoskeletal disorders.

Milton Keynes University Hospital NHS
NHS Foundation Trust

Meeting title	**Trust Board**	**Date: 02 November 2023**
Report title:	**Mortality Update**	**Agenda item: XX**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr Nikolaos Makris**	**Medical Director** **Associate Medical Director**
FoI status:	**Publicly disclosable**	

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

Report history	Periodic updates

Executive Summary

High-level *quantitative* metrics for the most recent 12-month rolling period available are as follows:

- The Trust's **crude mortality rate is 'first quartile'** when examined alongside its peers (1.13% compared to a national rate of 1.27%).

- The Trust's **HSMR is statistically 'mid-range'** when examined alongside its peers (rolling 12 months, to August 2023) (108.2 compared to 102.5).

- The Trust's **SHMI is in the 'as expected' category** (rolling 12 months to May 2023) (1.03 compared to 100)
- The **In-hospital SHMI** is slightly below the national benchmark (70.4 compared to 75.6). This **remains in the 'mid-range.**'

A variety of data definitions are included in **appendix 1**. The Trust has undertaken detailed work to better understand its position in relation to the risk-adjusted mortality indices (HSMR and SHMI), as some of the figures are numerically above the national average (although importantly within the expected range). Key factors from the review are:

- The frequency with which 'signs or symptoms' are coded as the primary diagnosis at MKUH has increased since the introduction of our Electronic Health Record (EHR). An inpatient admission is divided into a larger number of slides known as 'finished consultant episodes' (FCE). An FCE is the time spent under the care of a named consultant in a named specialty. Only information recorded in the initial two FCEs is considered in determining mortality statistics. A patient admitted with and dying from bilateral bronchopneumonia (a condition known to have a high mortality rate) may have their admission coded as the symptoms / signs of 'cough and dyspnoea' if the second FCE concludes before the necessary information is available to enable 'bilateral bronchopneumonia' to be recorded in the notes (and subsequently coded).
- While depth of coding (illustrated by Average Diagnoses per FCE) is in line with the national average, the proportion in hospital SHMI-spells with invalid or incomplete primary diagnoses is high amongst NHS Trusts (31.7%) These spells are mis-categorised into an incorrect diagnostic group, rendering them meaningless in the interpretation of mortality. The fact that a significant proportion of relevant hospital spells (almost a third) are not correctly risk adjusted may explain the disparity between the low crude mortality and the apparently high risk-adjusted mortality.

In relation to the *qualitative* review of deaths, MKUH has established a Medical Examiners' Office (MEO) which:

- reviews all hospital deaths and is expanding its role to review community deaths
- issues Medical Certificates of Cause of Death (MCCD) in conjunction with the primary doctor;
- liaises with / refers to the Coroner's Office; and,
- requests Structured Judgement Reviews (SJRs) from medical teams where potential concerns are raised by clinicians, family members or MEs.

The system is being expanded nationally to include review of all community deaths. This was initially anticipated to be complete by April 2023, but is now expected to become statutory in April 2024. The MEO is well placed to comply with this.

Main Report:

Quantitative data relating to mortality

Crude mortality data are shown in **Appendix 2a**.

HSMR data (supplied by CHKS) covering the period September 2022 – August 2023 are shown in **Appendices 2a and 2b**.

SHMI data (supplied by NHS Digital / CHKS) covering the period June 2022 – May 2023 are shown in **Appendices 2a and 2c**.

Since last year's Board Mortality Report, sepsis, both as a primary diagnosis, and as 'any diagnosis' during a hospital spell, has been added to the mortality dashboard (Appendix 2a.) This is in response to coronial concerns regarding the recognition of the deteriorating patient and treatment of sepsis. The Trust is in the 'first quartile' for sepsis as a primary diagnosis and 'mid-range' for sepsis as 'any diagnosis.' In addition, SJRs (see qualititative mortality review section), are requested in all patients where sepsis was the cause of or contributed to death.

Relevant contextual points in understanding the underlying data include:

- Palliative care coding was previously high compared to the national peer position but is now 'mid-range.' Work has previously been undertaken to demonstrate that the palliative care team only becomes involved in appropriate cases.
- Coding depth is in line with the peer position, with an average of 6.9 diagnoses per Finished Consultant Episode (FCE).
- Completeness of coding limits the accuracy and utility of risk-adjusted mortality indices. MKUH has a relatively high number of SHMI spells with an uncoded primary diagnosis amongst NHS Trusts. This results in large numbers of episodes being incorrectly risk adjusted, elevating the apparent values for SHMI. Discussions between NHS England and the clinical coding department are being arranged to understand and improve the picture. See **Appendix 3**
- 'Sign or symptom' coding (where signs or symptoms rather than an actual diagnosis are associated with the patient's episode of care) is high compared to the peer position, with 10.7% of admissions having a sign or symptom as a primary diagnosis compared to the national average of 9.1%.
- Percentage of 'zero-day length of stay admissions via the Emergency Department' was historically low compared to peer but has moved through mid-range in the last year and is now high. This was initially a result of changes to the recording of attendances at the Ambulatory Emergency Care Unit (AECU), which previously gave artificially low values for MKUH. The opening of the Maple Unit and the Same Day Emergency Care ward are likely to have contributed to this change.

Subset analysis of HSMR or SHMI (based on the '56 diagnostic baskets' making up HSMR, or 142 diagnostic groups making up SHMI) intermittently flags outlier status. Any outlier flags are reviewed and discussed at the Mortality Review Group (MRG). Current flags include pneumonia, fractured neck-of-femur and perinatal mortality. There are currently no flags that – following screening and analysis of individual patient records– lead the MRG to have cause of concern in respect of care quality.

Perinatal Mortality

The recording and review of stillbirths, late fetal losses and perinatal deaths in the Trust is carried out through the Perinatal Mortality Review Group (PMRG). This is a multi-disciplinary meeting consisting of Midwives, Obstetricians, Neonatologists and members of the Governance Team. It includes external reviewers alongside those from MKUH. Deaths are reported to the MBRRACE-UK perinatal mortality surveillance group in a standardised format (using the Perinatal Mortality Review Tool, PMRT).

Across Q2 (July to September 2023), there were five stillbirths (2.4 per 1000 births) and no neonatal deaths. One stillbirth has yet to be reviewed. The remaining four have been reviewed, with likely causes of death being given as: diabetes, chromosomal abnormalities, suspected placental abruption, and unknown.

PMRG examines the care received by the mothers from time of booking until delivery and assesses whether there were issues with care delivery and whether that may have made a difference to the outcome. In two of the four cases, issues were identified which may have influenced the outcome. These were: an earlier referral to foetal medicine and the initiation of aspirin in a mother who had previously delivered a small-for-gestational-age baby.
Learning from this group is collated into an action plan and disseminated via Clinical Governance Meetings, newsletters, teaching, and emails.

Qualitative data relating to mortality

Data from the Medical Examiners' Office for the last 15 months are illustrated in the table below.

	Q2 Jul-Sep 2022	Q3 Oct-Dec 2022	Q4 Jan-Mar 2023	Q1 Apr-Jun 2023	Q2 Jul-Sep 2023
Number of deaths	269	349	266	230	222
Number of deaths reviewed by Medical Examiner	100%	100%	100%	100%	100%
Number of SJRs Requested by Medical Examiner	28	25	28	28	38
% Deaths in which SJR requested	10.4%	7.2%	10.5%	12.2%	17.1%
Cases taken for investigation by the coroner following referral (% of total deaths)	14.4%	15.5%	10.9%	9.1%	13.9%
Cases in which MCCD (Form A) completed after discussion with Coroner (% of total deaths)	8.9%	12.9%	9.4%	12.6%	15.3%
% (Number) of Urgent Release completed paperwork within 24hours †	83% (5/6)	100% (2/2)	100% (2/2)	100% (4/4)	100% (5/5)
MCCD completion within 3 days	97%	91.4%	91.0%	91.3%	90.1%
Number of Relatives directed to PALS	7	13	8	8	11
Number of MCCDs rejected after Medical Examiner scrutiny	4	18	8	4	3
Deaths of people with Mental Health or Learning Disability diagnoses	4	0	0	1	0

All deaths in the Trust undergo review through the Medical Examiner system. Additional external review takes place for deaths accepted by the coroner for further investigation, paediatric deaths, perinatal deaths and deaths in patients with learning difficulties.

The ME system offers an objective review of the care delivered during the last hospital admission and is a point of contact for bereaved families or clinical teams to raise concerns about care prior to the death. Issues with care can also be highlighted by the Medical Examiner.

Deaths where concerns are raised regarding care undergo a formal Structured Judgement Review (SJR). SJRs are requested in all surgical deaths, a random selection of medical deaths, learning disability deaths, where sepsis is a cause of death, and in diagnoses where there is an HSMR alert.

SJRs are carried out by trained reviewers who look at the medical records in a critical manner and comment on specified phases of care. The output of the SJR is discussed at Mortality and Morbidity (M&M) Meetings. If a death is deemed potentially avoidable, or overall care delivery is rated as poor, then a second SJR is carried out at which point the case will be graded with an 'avoidability' score. The second SJR form should conclude with key learning messages from the case and actions to be taken.

In SJRs where concerns have been raised by family members, communication, either between teams or with the family, is the area most frequently highlighted by reviewers as requiring improvement.

A key area for development in the Trust's mortality review framework is gathering and collating evidence from this qualitative review work – both within the Medical Examiner's Office and in each clinical department which hosts M&M meetings and undertakes SJRs – to ensure that key themes are identified, and learning is shared and acted upon.

The web interface commissioned last year by the Trust to collate this information and allow near real-time tracking and review has now been completed. This allows the audit and comparison of SJR completion and outcomes from across the Trust, sharing of learning and coordination of quality improvement projects as part of the Patient Safety Investigation Response Framework (PSIRF.)

Divisional patient safety leads will provide quarterly updates to MRG on completion and outcomes of SJRs within their divisions and share key learning from M+M teams across patient safety teams.

The next iteration of this dashboard, currently in development, will allow the user to customise searches to whatever query they wish to answer in response to new questions or challenges with mortality data.

Appendix 1

Definitions

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

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

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

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

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

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

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

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

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

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

Appendix 2a

Summary Mortality Data

Metric	Period	Previous	Latest	National Peer	Variance	*Status*
HSMR	R12M to Aug-23	109.3	108.2	102.5	6.8	'Mid range'
SHMI	R12M to May-23	104.0	103.5	100.0	4.1	'As expected'
SHMI - In Hospital	R12M to Aug-23	72.1	70.4	75.6	-3.5	'Mid range'
Mortality Rate %	R12M to Aug-23	1.15	1.13	1.27	-0.12	'First Quartile'
Sepsis: In Hospital Mortality - primary diagnosis	R12M to Aug-23	15.3%	15.4%	19.1%	-3.8%	'First Quartile'
Sepsis: In Hospital Mortality - any diagnosis	R12M to Aug-23	22.9%	22.9%	21.7%	1.1%	'Mid range'
FCEs with palliative care code Z515	R12M to Aug-23	1.60%	1.6%	1.4%	0.2%	'Mid range'
Deaths with palliative care code Z515	R12M to Aug-23	46.76%	46.2%	41.2%	5.0%	Mid range'
Average Diagnoses per FCE	R12M to Aug-23	7.3	7.3	6.9	0.4	Mid range'
Sign or symptom as a primary diagnosis	R12M to Aug-23	11%	10.7%	9.1%	1.6%	Mid range'
% 0 Length of Stay Admissions via A&E	R12M to Aug-23	39.19%	41.4%	31.4%	10.0%	'Fourth Quartile'
Readmissions within 30 days	R12M to Aug-23	10.15%	10.4%	8.4%	2.0%	'Fourth Quartile'

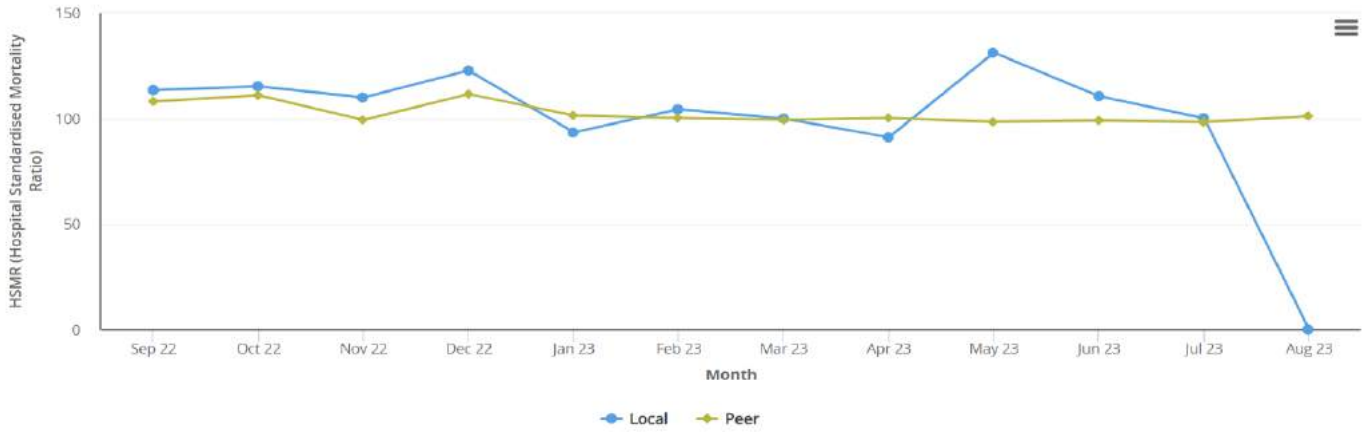
Appendix 2b

HSMR

HSMR	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul- 23	Aug-23
Trust Monthly	113.5	115.3	110.0	122.8	93.4	104.4	100.0	91.1	131.2	110.6	100.2	0.0
Trust 12 month rolling	113.3	113.5	113.8	114.5	113.0	112.2	111.5	109.2	112.1	112.2	109.3	108.2
National Peer 12 month rolling	104.3	104.7	104.6	105.8	105.4	105.4	105.4	105.2	104.9	104.4	103.1	102.5
Variance from the national peer	9.0	8.8	9.2	8.7	7.6	6.8	6.0	4.0	7.2	7.7	6.2	5.7

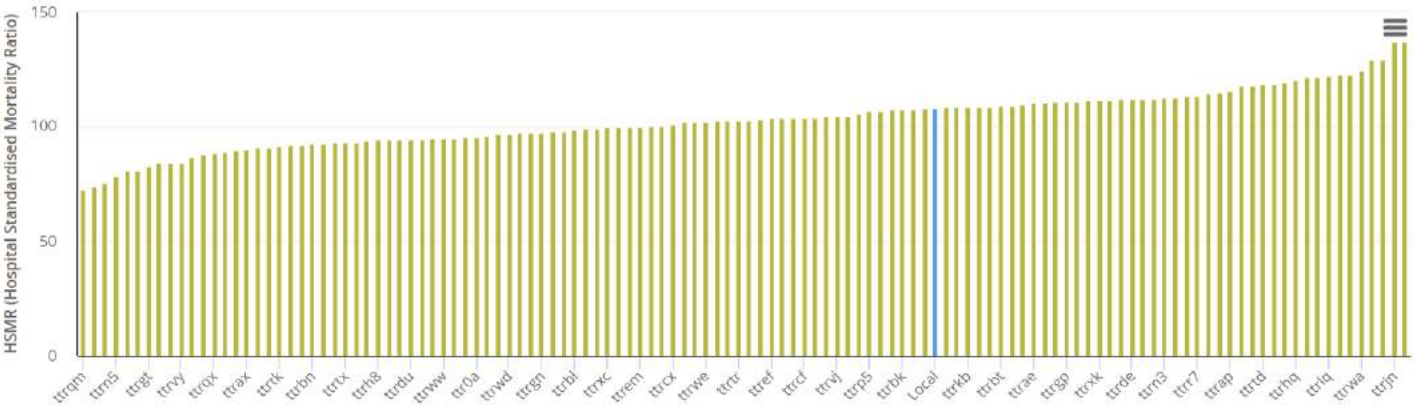
Table showing the last 12 months value for MKUH HSMR and rolling 12-month HSMR average in comparison to National Peer values.

HSMR, monthly



Line graph showing MKUH HSMR (blue) broadly tracking the national peer average. The August value is zero due to insufficient coding for that month.

HSMR, national peer comparison



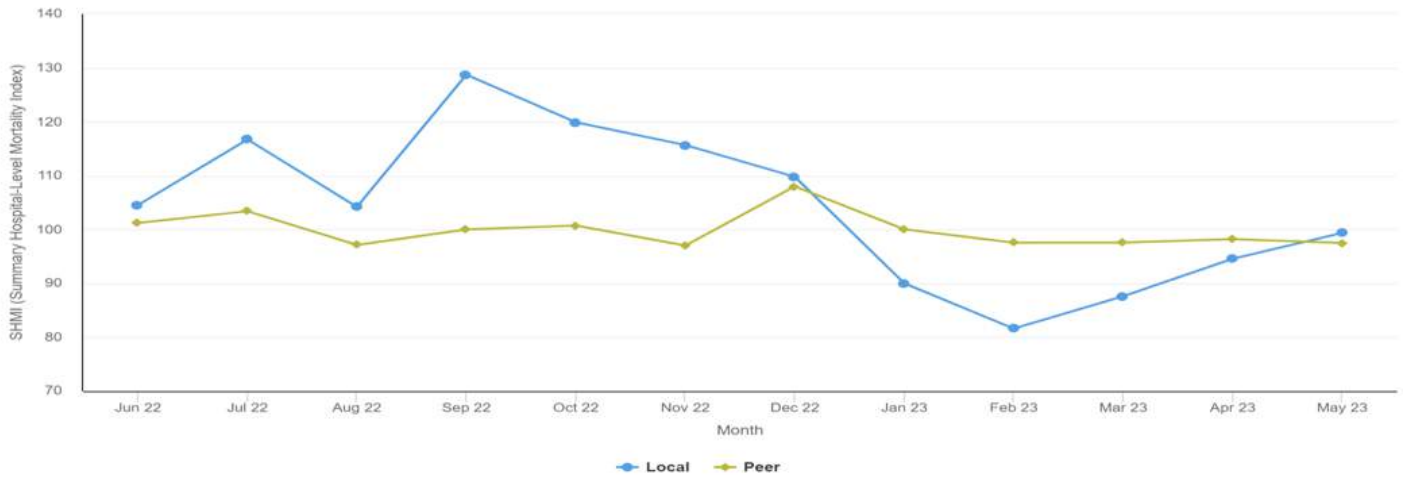
Bar graph showing MKUH HSMR (blue) in comparison to other Trusts.

Appendix 2c

SHMI

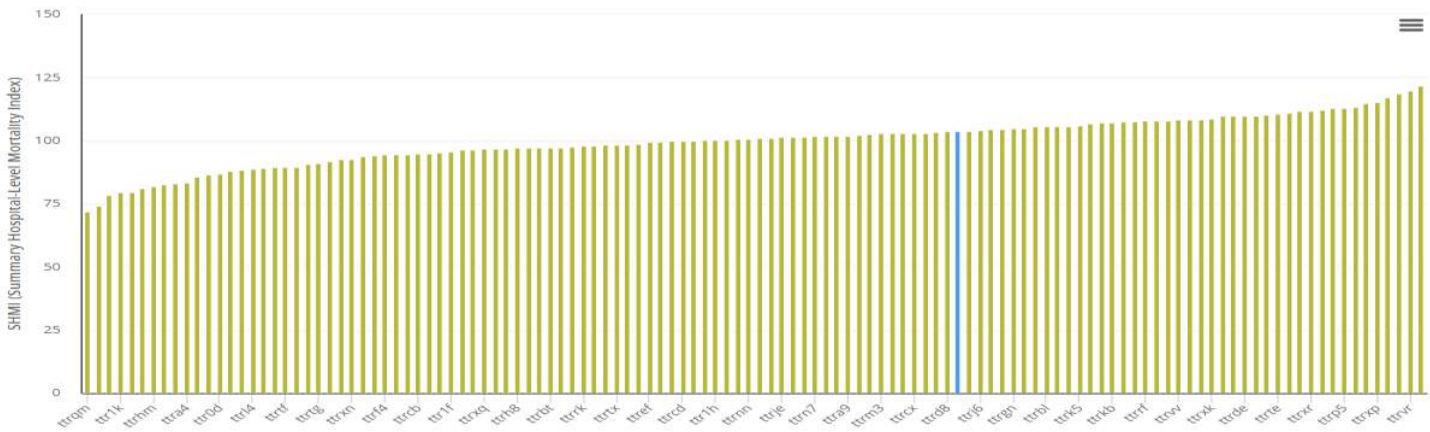
SHMI	Jun-22	Jul- 22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Trust Monthly	104.6	116.7	104.2	128.7	119.9	115.7	109.8	90.0	81.6	87.6	94.6	99.4
Trust 12 month rolling	106.0	105.4	105.2	107.5	109.6	109.3	110.5	108.5	107.5	106.2	103.8	103.5
National Peer 12 month rolling	100.4	100.7	100.6	100.5	100.4	100.1	101.1	101.1	101.0	100.6	100.3	100.0
Variance from the national peer	5.6	4.6	4.6	6.9	9.2	9.1	9.5	7.5	6.5	5.6	3.5	3.6

SHMI, monthly



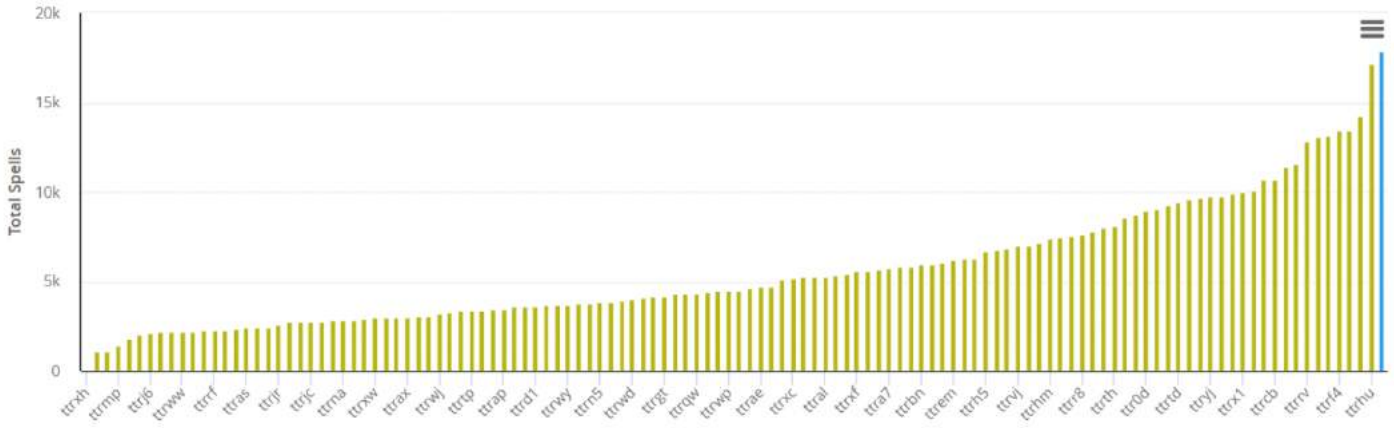
Line graph showing MKUH SHMI monthly (blue) in comparison to the National Peer.

SHMI, National peer comparison



Bar chart showing MKUH SHMI position (blue) in relation to other NHS Trusts.

Appendix 3



Bar chart showing MKUH uncoded primary diagnosis spells (blue) for the period June 2022-May 2023 in comparison to other Trusts. There are 17876 spells (or 31.8% of HES spells eligible for SHMI analysis) without a valid primary diagnosis. These include 48 deaths.
The invalid spells are placed in ‘Diagnostic Basket 140’ rendering them valueless for calculating indexed mortality. With such a large proportion of uncoded spells, the calculated SHMI value should be treated with caution. This data has been validated by NHS England, which provides SHMI calculations but there is no reason to suspect that it does not apply equally to HSMR spells. Improvement of coding of primary diagnosis will be critical in improving the accuracy and utility of MKUH’s indexed mortality data.

Meeting Title	Trust Board	**Date:** November 2023
Report Title	Maternity Assurance Group	**Agenda Item Number: 10**
Lead Director	Yvonne Christley - Chief Nurse, Board Level Maternity Safety Champion	
Report Author	Katie Selby – Women's Health Clinical Governance and Quality Improvement Lead	

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 key areas discussed and reviewed at MAG for September 2023 are summarised below: • Birth Forecast and Capacity MAG discussed the increase of maternity bookings and births in comparison to the previous time frame in 2022, which demonstrated an increase of bookings by 14% and births 9.7%. Further statistical analysis is to be undertaken to manage any increased acuity proactively. Workforce plans are being developed to manage any increase in demand. Midwifery Workforce 1. Progress has been made concerning the midwifery staffing budget to reflect the increased establishment calculated in Birthrate+ (six additional band six midwives). 2. Labour Ward Co-ordinator supernumerary status has remained at 100%. Saving Babies Lives v 3 1. The first baseline assessment of data had been completed with the LMNS and targets set. Further updates on compliance (50% in each element with an overall compliance above 70%) to be presented at CSU and MAG in November. 2. MDT TRAINING – There had been a new rotation of Doctors in August which decreased compliance. Plans had been implemented to support increase in compliance by December 2023. • Quarterly Safeguarding report MAG received a quarterly update on maternity safeguarding. This report provided assurances that robust maternity safeguarding pathways,

processes and procedures are achieved, and maintained, while identifying areas for improvement. It highlights key areas of identified improvement and the progress towards those, any challenges and escalations that are required.

- BSOTS Triage Feedback

MAG received a presentation regarding staff feedback on the dedicated maternity triage system called BSOTS. However, the feedback provided was from only a small number of staff and did not represent the views of the whole multidisciplinary team (MDT). In response, MAG requested more detailed input and extended the timescale for the report. The feedback that has been collected so far has identified improvements to support escalation in cases of high acuity, and the team is now working to implement these changes.

- Perinatal Quality Surveillance Model (PQSM)

The PQSM is a quality oversight tool that seeks to provide consistent and systematic oversight of maternity. The items summarised below were discussed as part of the PQSM:

1. The Perinatal Mortality Review Tool (PMRT) was used to review one stillbirth during the reporting period. This review was graded A before and after the birth, which means there were no issues with care identified.
2. NHS England (East Region) has reviewed the 2022 ONS data concerning stillbirths and noted an increase in BLMK. A thematic review of BLMK stillbirths has commenced for 2022 and is led by the LMNS. As part of this work, the Trust has initiated an MKUH thematic review and expects to report any findings at MAG in November 2023

- Community Connectivity

Community midwives have been provided with 5 G-enabled mobile phones that will allow them to connect to the electronic patient record. In addition, BT Wi-Fi X is also being made available and is expected to be in place by October 2023. Issues in GP surgeries are now resolved, and work is ongoing to fix connectivity problems within children's centres.

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 September 2023
Next Steps	N/A
Appendices/Attachments	N/A

Maternity Assurance Group (MAG)

Meeting Date:	28th September 2023	**Meeting Time:**	08:00 – 09:00
Location:	Microsoft Teams		

Present:	**Name**	**Job title**	**Initials**
	Alison Davis (Chair)	Chairman and Non-Executive Director	AD
	Dr Ian Reckless	Chief Medical Director Officer & Maternity Safety Champion	IR

In attendance:	Katie Selby, Maternity Governance and Quality Lead (KS) Dr Vicky Alner, Divisional Director, W&C (VA) Oliver Chandler, Head of IT Technical Services (OC) Mary Plummer, Maternity Matron (MP)
Apologies:	Katy Philpott, Associate Director of Operations, W&C (KP) Miss Nandini Gupta, Clinical Director Obstetrics and Gynaecology (NG) Yvonne Christley, Chief Nursing Officer and Maternity Safety Champion (YC)
Minute Taker:	Nicky Peddle – EA to Medical Director

Item	**Minute**	**Action**
1.	**Welcome and Introductions**	
	Apologies noted above.	
2.	**Declarations of interest**	
	None declared.	
3.	**Minutes of the last meeting**	
	The minutes of the meeting held on 24th August 2023 were accepted as an accurate record.	
4.	**Action log and matters arising**	
	Action 2: CNST - Midwifery workforce BirthratePlus undertaken in 2021 asserted that our establishment should be 6 WTE higher than the uplifted midwifery establishment post Ockenden in 2021/22 to meet CNST requirements. IR agreed to establish maternity finance position and report back to MAG. **Action 4: PSIRF update** IR advised that the Clinical Governance team have been through a consultation, there is now a future path in terms of the patient safety function team. KS confirmed that the Maternity is working collaboratively with Patient Safety Specialists. Pending agreement of the incoming Head of Maternity. For review in 3 months.	

	Action 18: BSOTS Ageda item. **Action 22: Training compliance** Agenda item. Action closed. **Action 23: Community connectivity** Agenda item. **Action 24: Maternity bookings** Agenda item. **Action 25: Culture Survey** Carried forward to October. **Action 26: Guidelines assurance** Agenda item. Action closed.	
	Standing items	
5.	**Perinatal Quality Surveillance Model**	

	Report taken as read. The following additional comments were highlighted and discussed:
	
	• Training: New rotation of doctors which has reduced compliance. Plan made with obstetric rota coordinator to ensure all staff have attended by December 2023.
	• PMRT:
	  ○ According to ONS data, BLMK is high for stillbirths. Our perinatal mortality rate is currently at 14 YTD compared to 12 this time last year. IR and YC to be sighted on clinical detail. Region have requested thematic review of 2022 data; KS gave assurance that this was undertaken in November 2022 and presented to MAG. Continuing thematic review is in place, data and actions monitored, no significant issues to report.
	  ○ In relation to SGA babies; in house smoking service in place and CO monitoring improved.	

6.	**CNST**	
	Report taken as read.	
7.	**Ockenden**	
	Report taken as read.	
	Assurance	
8.	**Quarterly safeguarding update**	
	KS provided a verbal overview as per the PDF circulated prior to the meeting, the following additional comments were highlighted and discussed: • Pause project – project that works with women who have experienced, or are at risk of, repeated pregnancies that result in children needing to be removed from their care.	

9.	**Updated maternity bookings**	
	September update: overall increase in bookings and births from this time last year; 14% and 9.7% respectively. Whilst there was a reduction in bookings this month, it is anticipated that bookings will increase again. **action** MAG requested a statistical process control chart of monthly bookings and deliveries over last 3 years.	KP
10.	**BSOTS staff feedback survey**	
	KS provided a verbal overview as per the PDF circulated prior to the meeting, the following additional comments were highlighted and discussed: • It is felt by the region that this model is quite inflexible • Perimeters around timescales to review patients needs to be written into BSOTS. **action** MAG requested confirmation of self-discharge rate after triage.	KS
11.	**Community connectivity update**	
	OC provided a verbal update: • 5G has been enabled on all SIM cards Trust wide. A number of midwives do not have a device capable of 5G. In mitigation, 20 new phones have been ordered and will be distributed over the next few weeks. • BT Wi-Fi-X will be coming online Trust wide in approximately 2 weeks' time. This allows devices to auto connect without the user having to login via a landing page. Trialled by IT and works particularly well in areas of low coverage, i.e., Stony Stratford. • Issues with connectivity in GPs surgeries has been resolved and closed. Formal agreements in place with the IT provider for the community and MKUH IT technical team to set up and manage devices. • Issues with respect to MKCC children's centres; work is ongoing to resolve. IT is looking into other solutions. • Feedback from Midwives to be collated weekly. **action** MAG requested an update in November. If assurance is given that any remaining connectivity issues are understood, and Midwives /IT are confident mitigations are working, action can be closed.	IR
12.	**Guidelines assurance**	
	KS provided a verbal overview as per the PDF circulated prior to the meeting, the following additional comments were highlighted and discussed: • MAG agreed a risk-based approach to extending time frames for screening guidelines by 6 months. For assurance, KS agreed to review guidelines to ensure there have been no significant has changes prior to extension.	
13.	**AOB**	

	• Maternity 2023 survey EMBARGOED results released. Headlines:
	  ○ Induction of labour very low
	  ○ Breastfeeding has declined. MP has taken on the infant feed lead and will review evidence and audits ahead of BFI accreditation later this year. Training has been standardised for all Midwives/NNU and meets with BFI standards. Review of artificial feeding provided outside of medical advice is ongoing.
	action review of Maternity Survey and Culture survey at next MAG.	

14.	Date and time of Next Meeting	
	Thursday 26th October 2023 @ 08:00-09:00 via MS Teams	

Meeting Title	**Trust Board Meeting in Public**	**Date: 02 November 2023**
Report Title	**Safeguarding Annual Report 2022-2023**	**Agenda Item Number: 11**
Lead Director	**Yvonne Christly - Chief Nursing Officer**	
Report Author	**Julie Orr- Associate Chief Nurse - Operations& Safeguarding**	

Introduction	This Annual Report on Safeguarding Adults and Children activity at MKUH between for 2022/2023.		
Key Messages to Note	The Milton Keynes University Hospital Foundation Trust (MKUHFT) has a statutory obligation to establish safe and efficient systems to safeguard adults, children, and young people who may be at risk of abuse, neglect, or exploitation. This annual report summarises the Trust's Safeguarding activities from April 2022 to March 2023. The report highlights the increased activity and complexity of adult and child safeguarding cases. The report has several objectives, including assuring the Board that the Trust is fulfilling its safeguarding obligations. The report also provides an overview of the support offered by the Safeguarding Team to operational and clinical services. Additionally, it emphasises the Trust's priority to safeguard children and adults and provides an overview of local and national developments in the safeguarding over the past 12 months. The report highlights how these developments have impacted the Trust's service and how we work as a partnership to protect patients and their families accessing Milton Keynes services. In the past year, the operational leadership has transitioned into the Associate Chief Nurse (Safeguarding and Operations) portfolio. This has strengthened the leadership and oversight of safeguarding activities. The safeguarding team has also grown with the addition of a clinical educator for MCA/DOLs. The Trust is currently engaged in the recruitment of a Head of Safeguarding and an Adult Safeguarding lead. A detailed improvement programme is underway to revise and update all adult and children safeguarding policies, procedures, and guidelines. The Board is asked to note and approve the content of this report.		
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*

Report History	*The name of the committee(s) or governance group that considered the report, and date(s) on which the report was considered.*
Next Steps	*State whether this report shall be considered by another committee or the Trust Board.*
Appendices/Attachments	*List of Attached Reports (See Appendix xxx)*

1.0 Introduction

This report summarises the safeguarding activities undertaken by Milton Keynes University Hospital Foundation Trust (MKUHFT) to safeguard and promote the welfare of children, young people, and adults at risk between April 2022 and March 2023. The report also outlines safeguarding activity and highlights the achievements, challenges, and priorities during the reporting period. The report covers safeguarding activity with a focus on five areas:

1. Governance
2. Assurance
3. Profile and types of activity
4. Training and Education
5. Learning Disability
6. Future Recommendations

All safeguarding work across the Trust is underpinned by the Trust values:

We CARE: We deliver safe, effective, and high-quality care for every patient, and we treat everyone with dignity, respect and compassion.

We COMMUNICATE: We keep patients informed about and involved and engaged in their treatment and care; and each other informed. We know we can speak up to make sure our hospital is safe.

We COLLABORATE: We work together and with GPs, primary care, community care, social care and mental health providers and other hospitals to deliver great care and services for people.

We CONTRIBUTE: We develop goals and objectives in support of the hospital's vision and strategy. We acknowledge and share good practice and we learn from others so that we keep improving the care and services we provide.

2.0 Governance

The Chief Nurse is the Executive Director for Safeguarding and has strategic responsibility for safeguarding children and adult functions in the Trust. The Associate Chief Nurse for Operations and Safeguarding has delegated responsibilities for safeguarding leadership and coordinating the corporate safeguarding teams to ensure that the Trust safeguarding agenda and work plan are aligned with the MK Together Safeguarding Partnership Board.

At present the Head of Safeguarding is on an extended secondment, and the post is currently out to recruitment. There are Named Lead Professionals for Safeguarding Adults, Children and Maternity. These professionals provide expert operational-level support across the Trust. The current Safeguarding Adults Lead post will be advertised as a developmental opportunity following previous attempts to recruit without success.

The Safeguarding Adult Lead is supported by a Specialist Nurse for Vulnerable Adults and the Children's Safeguarding Lead is supported by a Specialist Nurse for Safeguarding Children. The Safeguarding team are supported by a small administrator team, including a Data Analyst/ Administrator role.

3.0 Assurance

The Trust's safeguarding responsibilities are guided by the statutory requirements detailed in the Working Together to Safeguard Children Report (2015), the Care Act 2014 and the Care Quality Commission.

MKUHFT has a clear governance structure which includes the investigation of incidents and complaints. Incidents and complaints involving safeguarding concerns are dealt with promptly, and where appropriate, action plans are formulated to improve practice and share learning. Safeguarding incidents are monitored by the Trust's Safeguarding Committee.

The Trust assesses itself against the Safeguarding Self-Assessment and Assurance Frameworks (SAAF) provided to the Trust (commissioned by the Integrated Care Board (ICB) on an annual basis. The standards related to safeguarding adults' practices, the results of which are presented and discussed at the Trusts Safeguarding Committee.
3.4 The Trust also completes a self-assessment related to the Children Act 2004 – Section 11 Safeguarding Assurance Self-Assessment Framework. The standards relate to safeguarding practices and provide assurance that the Trust is safeguarding vulnerable children and young people.

A detailed improvement programme has commenced to review and update the MKUHFT adult, children, and maternity-related safeguarding policies, procedures, and guidelines. A gap analysis has been completed, identifying areas of strength in the Trust's approach to safeguarding adults and children and systematically identifying required focus and improvement.

The Trust's internal assurance process includes the Safeguarding Committee, which has been reviewed and will now meet monthly instead of quarterly. The Safeguarding Committee reports to Patient Safety Board and to the Quality and Clinical Risk Committee. The Trust also actively participates in and is represented across MK Together affiliate boards summarised below.

Internal Meeting Representation	**External Meeting Representation**
• Nursing Midwifery Therapy Advisory Group • Care Assurance • Trust Senior Sister/ Matron meeting • Serious Incident Review Group • Safeguarding leads forum TBC • Safeguarding Committee • Section 42 panel • Patient Safety Board • Clinical Board/Clinical Quality Board • Daily Safety Huddle • Violence and aggression group • Care Review and Learning Panel	• MK Together Review Board • MK Together Assurance Board • MK Together Partnership Board • MARAC • SG Escalation/ Review Meetings/CAMHs • Interface Meeting • Prevent Board • Navigator Meeting • LeDeR panel • LeDeR Assurance Board • MASH Interface Meeting • Unborn Planning Meeting • MEP • BLMK Child Death • East of England Safeguarding Forum • Domestic Violence Strategic Partnership Board

4.0 Profile and Types of Safeguarding Activity

Safeguarding Adults (SGA)

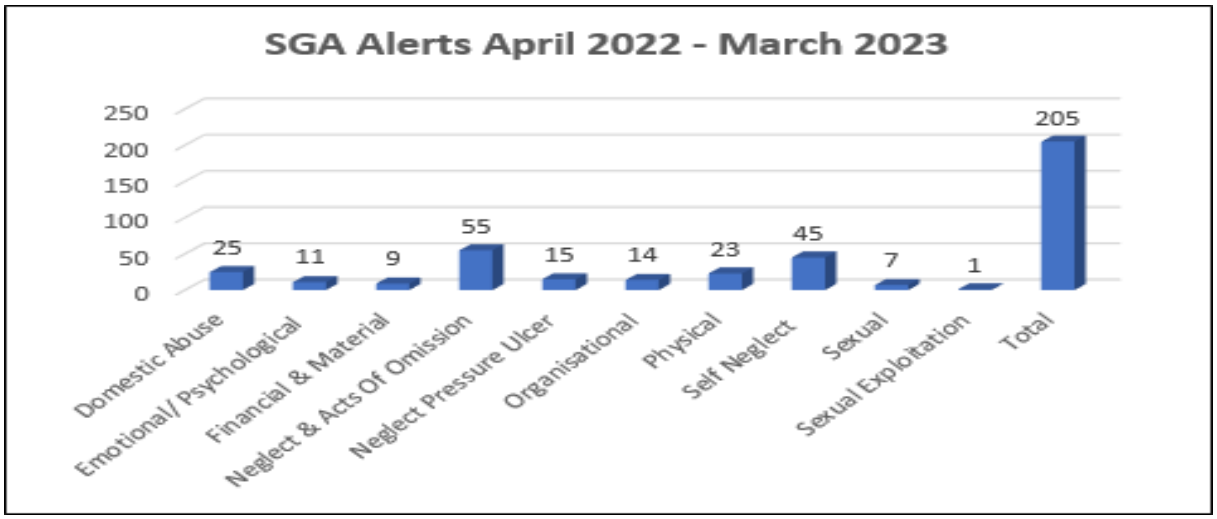
The Safeguarding Team offers advice and practical assistance for various safeguarding concerns related to adults at risk of abuse through deliberate actions or neglect. In the past year, the team has strived to increase awareness of safeguarding throughout the Trust to incorporate safeguarding processes into MKUH's everyday practice. The team is highly visible clinically so that staff feel informed and confident in seeking safeguarding guidance.

Safeguarding Adult Alerts & Concerns

There were 205 safeguarding adult alerts made by Trust staff during the reporting period. The Safeguarding Adult Alerts by month for the reporting period are summarised in the chart below. In total there were 205 alerts raised by MKUHFT in the past year, a slight decrease compared with the 2021-2022 activity of 228.

Safeguarding Adult Alerts April 2022 – April 2023

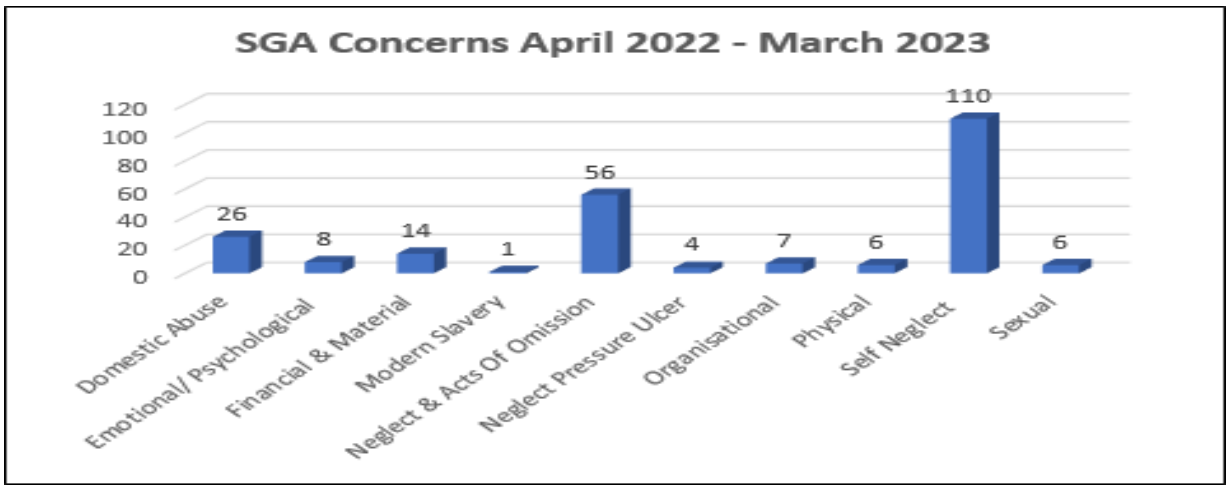
These alerts mainly relate to neglect, acts of omission, self-neglect, domestic abuse, and physical abuse. These categories are in keeping with 2021-2022 data and are summarised in the chart below.



In 2022-23 neglect and acts of omission remain the highest category of abuse in safeguarding adult referrals followed by domestic abuse. This is reflective of the local and national picture.

There were 238 safeguarding concerns raised in 2022-2023 compared with 165 in 2021-2022. The concerns raised relate to both internal and external safeguarding enquiries. The recent addition of the South-Central Ambulance Service (SCAS) data in October 2022 partly accounts for the rise in numbers compared with 2021-2022.

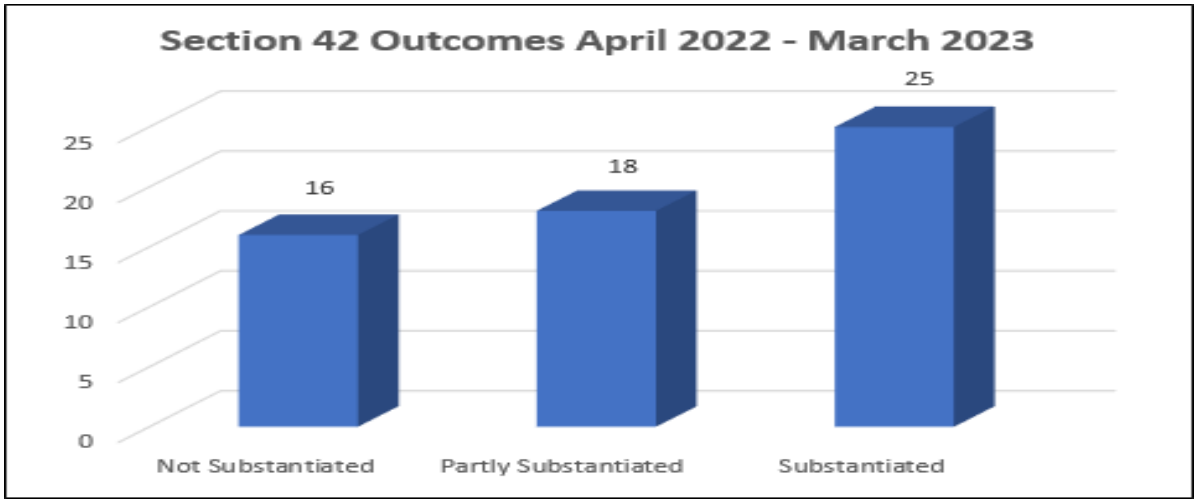
The chart below highlights the themes of referrals made during this reporting period with neglect/or act of omission and self-neglect highlighted as the two highest levels of safeguarding adult concern.



5.0 Section 42 Enquiry (S42)

A section 42 enquiry relates to the duty of the Local Authority to make enquiries, if an adult may be at risk of abuse or neglect and are to be completed within a 28-day enquiry pathway. In 2022/23 there were 65 Section 42 enquiries compared with 32 in 2021-2022 related for the most part to neglect or acts of omission (59%) and pressure ulcers (34%). Of the total number of section 42 investigations, 25 (43%) were substantiated, 18 (30%) were partially substantiated, and 16 (27%) were found to be unsubstantiated. Responses were all shared with the divisions involved.

Safeguarding concerns that are raised via Section 42 Enquiries predominantly refer to discharge arrangements in terms of timeliness, completeness of arrangements (i.e., home care package) and communication with carers and families prior to discharge. The outcome of safeguarding investigations is shared with staff members via ward / department meetings, matron and ward sister meetings to review and instigate processes/clinical practice to prevent similar incidents from occurring.



The Safeguarding Team works with the Local Authority to ensure that the proper procedures are followed for Section 42 inquiries. They also assist the divisions in completing the process to address any safeguarding concerns. The Trust is thematically reviewing the section 42 investigation process to ensure the investigation findings and lessons learned are shared more widely. The aim is to create a culture where everyone is responsible for safeguarding and preventing similar incidents from happening.

6.0 Deprivation of Liberty Safeguards (DoLS)

The purpose of the Deprivation of Liberty Safeguards (DoLS) is to protect the rights of individuals who lack the mental capacity to make certain decisions for themselves. The DoLS ensure that the trust prioritises liberty and autonomy when planning care and avoids the need

to restrict an individual's liberty. The DoLS are based on the empowering principles of the Mental Capacity Act (2005). The Safeguarding Team is responsible for managing and administering the DoLS process for the Trust. They carefully review each DoLS application before sending it to the patient's local authority. The team ensures that the application includes:

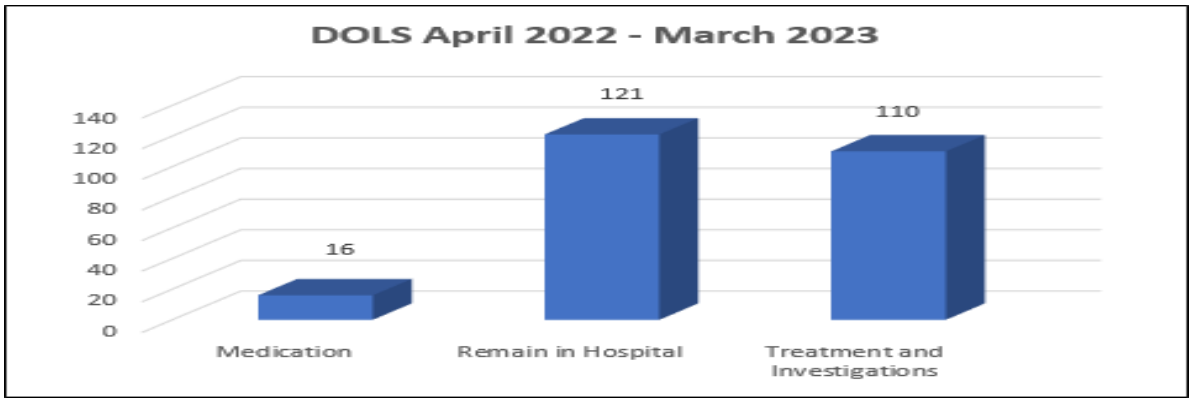
- A documented mental capacity assessment that is relevant to the individual.
- An accurate, appropriate, and comprehensive DoLS application.
- The appropriate use of Sections 5 and 6 of the Mental Capacity Act.

MKUHFT applied for a total of a total of 247 urgent DoLS in 2022-2023, this is a 28.3% increase on 2021-2022 which was 177. This is in part attributed to:

- The Enhanced Observer Process and focused review with Matrons.
- The drive from the Safeguarding Team on the Daily Safety Huddle to identify the gaps between numbers of patients with dementia/ confusion and the current level of DoLS.
- Introduction of a Mental Health Practice Educator to improve staff understanding/training.

The Trust's Safeguarding Team is collaborating with IT colleagues to integrate the mental capacity assessment into e-Care. This will ensure that the assessment is consistently recorded and easily accessible. Additionally, the team offers guidance and training on capacity assessment and completion of DoLS applications tailored to specific areas. Introducing a Mental Practice Educator has further improved the accessibility and distribution of ward-based information resources. It has helped raise awareness of MCA's implementation and legal responsibilities in the clinical areas.

The three categories of DoLS applications are summarised in the table below:



There has also been an increase in patients requiring standard DoLS due to delays with discharge and access to appropriate placements, care packages, and out-of-area discharge delays. This is primarily linked to the patient's inability to consent to discharge or discharge destination.

7.0 Health Independent Domestic Violence Advisor (HIDVA)

The health IDVA role supports and enables identification, support and onward referral processes for patients and staff who are experiencing domestic abuse. The number of referrals for the reporting period doubled in January and February. The role links directly to

the MK ACT domestic abuse intervention service. The HIDVA also contributes actively to with the Safeguarding Team to deliver domestic abuse training and is a core part of the safeguarding Committee.

An Additional HIDVA post is being recruited to and MK ACT. MKUHFT has started to receive data from MK ACT and the YTD data is awaited however the first three quarters of the year highlighted **107** new referrals, primarily from the Emergency Department, Maternity, and outpatient settings. The top types of support offered are:

- emotional support
- safety planning
- practical support
- sign posting
- risk assessments

8.0 Hospital Navigator Scheme

The Hospital Navigator Scheme is a pilot initiative introduced by Thames Valley Police (TVP) to reduce violent crime across the region. MKUHFT is one of five hospitals across the Thames Valley region participating in the pilot. TVP identified an increase in patients presenting at Emergency Departments (ED) or walk-in centres due to incidents of serious violence related to domestic violence and individuals under the age of 25.

The Hospital Navigator aims to help these patients find alternative pathways to deal with their situation by providing practical, achievable, and supported options. The Navigator scheme has been successful at MKUHFT, and referral and outcome data are currently being collected.

9.0 Learning Disabilities

In 2022-2023, 560 people with a learning disability received care from the Trust. The Trust has analysed its practices based on the NHS England Learning Disability Benchmarking Standards and has shown improvement in various aspects. These include working more closely with local care and residential homes to develop personalised care plans before hospitalisation, creating individualised hospital passports on eCare, incorporating flags on eCare for patients with learning disability, and offering flexible and inclusive visiting options for families and caregivers.

The Trust has also started additional work to improve services, such as training staff to provide individualised care planning from the perspective of patients and their caregivers. Work has also commenced collaborating with patients, their families, and caregivers to develop a care pathway that meets their scheduled and unscheduled care needs. Written communication is also being enhanced, as are signage and easy-read appointment letters.

Learning Disabilities Mortality Review

All deaths related to learning disabilities are reported and reviewed through the LeDeR panel. In 2022-2023, there were eight learning disabilities deaths that were reviewed through the LeDeR panel. The Trust has a standard pathway to report any death of a person who has a

learning disability, and LeDeR notifications are made through the Safeguarding Team from a Radar Report. The Trust safeguarding team and LD specialist nurses attend and contribute to the LeDeR reviews and share any learning across the Trust. Any learning from the LeDeR review is shared and incorporated into the safeguarding training and supervision.

10.0 Case Reviews (Domestic Homicide Reviews, Safeguarding Adult Reviews/ Children Reviews)

Domestic Homicide Reviews are multi-agency statutory reviews under the Domestic Violence, Crime and Victims Act 2004. They involve a multi-agency review of circumstances where a person aged 16 or over has died due to violence, abuse, or neglect from someone they were related to, in an intimate relationship with, or sharing a household. The goal is to examine the circumstances surrounding the death thoroughly.

MK Together Partnership coordinates and commissions the reviews. For each review, there is a chronology of all services involved with each case, which may also include the person's family, friends, and employers. Currently, the Trust is participating in three domestic homicide reviews (each review could take over 6-12 months to complete).

The Trust is also involved in two safeguarding adult and one child review. One of the adult safeguarding reviews has been recommended for independent scrutiny. This is to ensure a stronger "Think Family" approach and to share any identified learning. In the 2022-2023 reporting period the Trust made no direct referrals to the LADO.

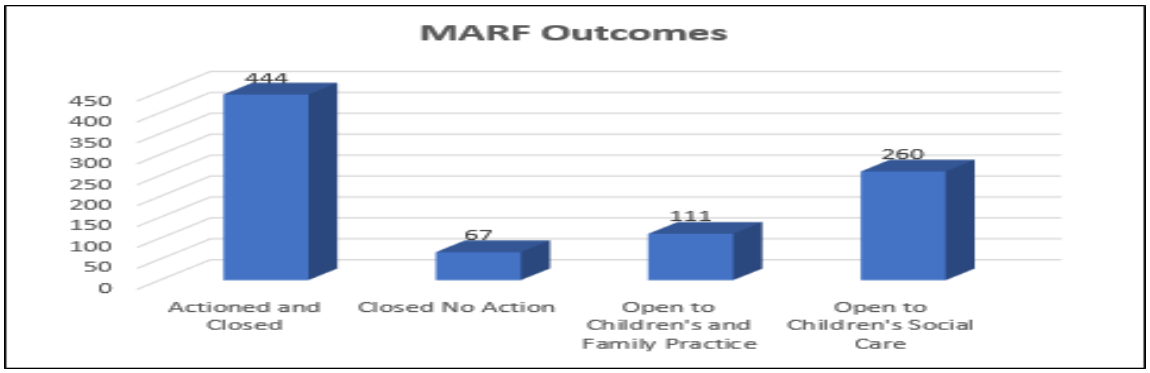
11.0 Safeguarding Children and Young People

The Safeguarding team are committed to safeguarding and promoting the health and well-being of all children and young people attending the Emergency Department (ED), as outpatients or, those admitted to the paediatric wards, the paediatric assessment unit, or any adult wards where 16-year-olds require support. The Trust also has a duty toward ‘unseen’ children whose parents have been admitted or have attended ED where safeguarding concerns may exist.

Multi-Agency Referral Forms (MARF)

In 2022-2023, there were 793 multi-agency referrals for safeguarding concerns related to children and young people. This figure represents a 6% increase compared to the previous year. The Trust observed a notable referral rise in January and February 2023, particularly in the Emergency Department. The increase is primarily due to child and adolescent mental health issues like self-harm and eating disorders. Furthermore, there have been significant delays in finding suitable placements and discharging children and young people with mental health problems due to a shortage of available placements. The outcomes of MARF referrals are summarised below:

MARF Safeguarding Children's Referral Outcomes (April 2022- March 2023)



The themes from MARF referrals relate to neglect, emotional abuse, domestic abuse, child and adolescent mental health and delays with discharge. Joint work with the CAMHS and Social Care to reduce delays and the impact on families has been a priority to minimise the effects on children and families.

Sharing Information Forms 0–19year-olds

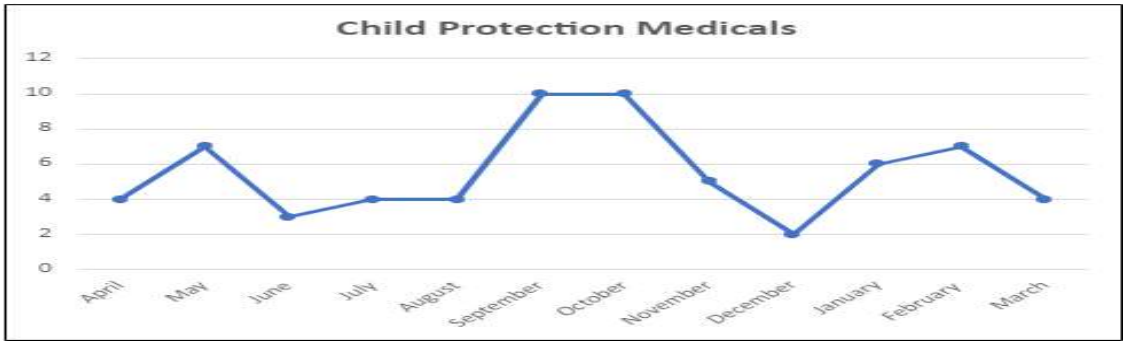
The Emergency Department fills out information forms for the Health Visiting and School Nursing teams and the universal 0 to 19 team. These forms contain details about children who have attended the Emergency Department and about whom there is a safeguarding concern. Once the safeguarding team has reviewed the information and ensured all necessary actions have been taken, the forms are emailed to the relevant universal services. In 2022-2023, the Trust has completed 1217 sharing information forms. Additionally, the Trust has started digitising the form and enhancing the recording of young people aged 16-18 who visit the Emergency Department.

Child Protection Medicals (CP medicals)

The Trust has reported a 33% rise in Child Protection Medicals conducted during 2022-2023, totalling 66 compared to 44 in 2021-2022.

A review of the Child Protection Medicals is underway in Milton Keynes. Key stakeholders from MKUHFT, Milton Keynes City Council, Central Northwest London Trust (CNWL), and the BLMK Integrated Care Board are collaborating to develop a system-wide approach to enhance the pathway for children and young people needing Child Protection Medical. This includes evaluating how child neglect medicals are currently managed in Milton Keynes.

YTD Child Protection Medical Activity



12.0 Maternity Safeguarding

Since May 2022, the Trust has had a Named Midwife for Safeguarding and a Perinatal Mental Health Specialist Midwife. The Named Midwife for Safeguarding supports hospital and community-based staff and ensures that safeguarding is integrated into all aspects of maternity practice. The role of the Named Midwife is to provide guidance, supervision, and training within maternity services. They also represent the Trust in maternal and child safeguarding issues meetings and ensure compliance in MKUH with the local and national safeguarding agenda. The Named Midwife for Safeguarding has been trained in clinical supervision, which is demonstrated by supervision sessions on Healthroster.

A safeguarding guideline for maternity is currently being developed. This guideline will detail the necessary steps to take when a safety concern arises in the context of maternity services. It will ensure that all individuals impacted, both adults and children, receive the necessary therapeutic and preventative interventions promptly and appropriately.

The Unborn Baby Panel takes place monthly within the Multi-Agency Safeguarding Hub. This supports the Named Midwife for Safeguarding to receive and share information with social worker colleagues, strengthening communication and formulating clear care plans for service users.

13.0 Safeguarding Adults and Childrens Training

Providing effective safeguarding training and education is crucial for building staff confidence and skills in safeguarding. All staff must understand their roles and responsibilities, as well as the proper procedures to follow to safeguard their patients.

The Trust's key performance indicator (KPI) for safeguarding training is 90%. The Adult and the Children Safeguarding Training Intercollegiate guidance informs the Trust's approach and learning outcomes. E-Learning for Health (Health Education England) provides online safeguarding training and is supplemented with additional face-to-face training. Training compliance is monitored by the Trust's Safeguarding Committee and by the Learning and Development Department.

Safeguarding Adults & Children/ Mental Capacity Act Training Compliance

Safeguarding Adults Training	Q1	Q2	Q3	Q4	YTD Average
Safeguarding Adults Level 1	96%	96%	96%	96%	96%
Safeguarding Adults Level 2	96%	95%	96%	95%	96%
Mental Capacity Act	94%	94%	94%	93%	94%
Safeguarding Children Training	**Q1**	**Q2**	**Q3**	**Q4**	**YTD Average**
Safeguarding Children Level 1	96%	96%	97%	95%	96%
Safeguarding Children Level 2	96%	96%	95%	95%	96%
Safeguarding Children Level 3	96%	94%	92%	92%	93%

The Trust has also appointed a Mental Health Educator and will focus on improving the education, training and compliance related to MCA and DOLS.

14.0 Prevent and WRAP Training

Prevent is a counter-terrorism strategy in the United Kingdom that aims to protect individuals who may be exposed to radicalization and extreme ideologies. Basic Prevent Training equips staff with the necessary knowledge and skills to identify and refer individuals who may be at risk of radicalization. The Trust has maintained consistently above 90% for Prevent awareness training as summarised in the table below:

Prevent Awareness Training BPAT 2022-2023				
Q1	Q2	Q3	Q4	Average
97%	97%	97%	97%	97%

WRAP Training is a Home Office training package for frontline staff in the private and public sectors. It provides an overview of the Prevent Strategy and ways of identifying individuals at risk of radicalisation as well as those who radicalise. The Trust has maintained consistently above 90% for Prevent awareness training as summarised in the table below:

WRAP 2022-2023				
Q1	Q2	Q3	Q4	Average
94%	93%	93%	93%	93%

15.0 Key Challenges in 2022/2023

During the reporting period, there were several challenges that the Trust faced, which are summarised below:

- There has been an increase in the complexity of child and adult safeguarding activities. This includes mental health, maternity, domestic abuse, and neglect. This rise in complexity is mirrored in national and local safeguarding activities. Such cases require extended and ongoing support from the Trust safeguarding team.
- There has been an increase in the number of children with complex safeguarding mental health self-harming behaviours. Due to delays in identifying appropriate placements by social care or CAMHS, these children have prolonged stays in the hospital.
- Safeguarding is a demanding and specialised role, and recruiting staff with the required skills has been challenging. This remains an ongoing challenge and an area of risk.

16.0 Future Developments in 2023/2024

In 2022/2023, the focus of the Trust's activity will be on implementing the national and local safeguarding agendas while strengthening partnerships across Milton Keynes and beyond. Key areas of focus in the coming year will be on:

- MCA training and assessments, including paediatrics.
- A workforce review of the Trust Safeguarding Team, including recruitment and an alignment of structure and safeguarding expertise to ensure the team meets the needs of patients and staff.
- Recruitment to essential posts in Dementia and Learning Disabilities.
- Increasing the availability of safeguarding supervision in adult, children, and maternity services.
- Sharing learning from safeguarding and domestic homicide reviews (adults/children).
- Providing bespoke safeguarding learning events to complement the Trust's eLearning training packages.
- Providing MDT safeguarding training**.**

17.0 Conclusion

This Annual Report demonstrates that safeguarding vulnerable people remains a priority for the Trust. The Trust continues to meet its statutory duties while proactively developing safeguarding provisions and mechanisms for learning. At MKUHFT, the Safeguarding Team is continuously growing and collaborating with partner agencies to comply with the Children Act 2004 and Care Act 2014. The Trust is committed to identifying concerns and protecting vulnerable individuals which is demonstrated through significant multiagency working over the past year.

18.0 Recommendation

The Board is asked to note and approve the content of this report.

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**Trust Board Meeting in Public**	**Date: 02 November 2023**
Report Title	**Complaints and PALS Annual Report 2022/23**	**Agenda Item Number: 12**
Lead Director	*Kate Jarman, Chief Corporate Affairs & Communications Officer*	
Report Author	*Julie Goodman, Head of Patient and Family Experience*	

Introduction	*To provide assurance to the Board regarding the regulated complaint handling within the organisation in line with the requirements of the national complaint regulations. To provide an annual overview of the themes and trends from complaints and the areas in which they are occurring.*	
Key Messages to Note	*There has been a small increase in the number of reportable complaints in 2022/23 of approximately 9%.* *Issues raised in complaints have become more complex and very often involve a multi-disciplinary investigation.* *Informal complaints are often regarding appointment issues or waiting times for procedures, this is replicated across the NHS.*	
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]
Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care* 5. *Employ the best people to care for you*	
Report History	*Patient and Family Experience Board*	
Next Steps	*Trust Board.*	
Appendices/Attachments	*None*	

SUBJECT Complaints Annual Report

DATE April 2022 to March 2023

REPORT BY Julie Goodman, Head of Patient and Family Experience

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1. Executive Summary

This is the complaints annual report for Milton Keynes University Hospital NHS Foundation Trust (MKUH) for the period 1 April 2022 to 31 March 2023. In this year there were:

- 101212 attendees to the Emergency Department
- 25568 elective admissions
- 28118 emergency admissions
- 413979 outpatient attendances
- 3514 babies delivered.

The National Health Service Complaints (England) Regulations 2009 state that all Trusts must prepare an annual report on the handling and consideration of complaints. This report provides detail on the required inclusions and will be made public on the Trust's website and sent to the commissioners of the Trust.

National regulations are further supported by the publication of national reports including the Francis Report 2013, Clwyd and Hart Report 2013, Designing Good Together Parliamentary and Health Service Ombudsman (PHSO) 2013, and My Expectations for Raising Concerns and Complaints (PHSO) 2015. All reports highlight best practice in respect of dealing with concerns and complaints. Extensive analysis of the NHS England's toolkit - 'Assurance of Good Complaints Handling for Acute and Community Care - A toolkit for commissioners', has demonstrated that the Trust's complaints service and process is robust and accessible to our public.

Complaints are an important feedback tool and are a strong indicator of patient experience. The vision of the Trust is that we want all people using our services to be able to say, 'I feel confident to speak up and making my complaint was simple', 'I felt listened to and understood', and 'I felt that my complaint made a difference'.

2. Summary of NHS Complaints Procedures

In April 2009 the NHS Complaints Procedure was amended and the latest NHS (Complaints) Regulations came into force. The Local Authority Social Services and NHS Complaints (England) Regulations 2009 are a Statutory Instrument that all Trusts including Foundation Trusts have a duty to implement. Whilst the procedures are not prescriptive the regulations set out various obligations for NHS bodies in relation to the handling of complaints. Since 1st April 2009 there has been a single approach

across Health and Adult Social Care in dealing with complaints. The regulations set out a two-stage complaint system:

Stage 1 Local resolution – working with the complainant to understand and resolve their concerns in a timely and proportionate way.

Stage 2 Referral to the Parliamentary and Health Service Ombudsman (PHSO) – if local resolution is not successful and complainants are dissatisfied with the way their complaint has been handled, they can refer their case to the Ombudsman for review.

National complaints legislation requires that concerns raised by the public are responded to personally and positively and that lessons are learnt by the local organisation. The local resolution stage focuses on the complainant and enabling organisations to tailor a flexible response that seeks to ensure all complainants receive a positive response to their complaint or concern. It places an emphasis on resolving complaints or concerns as fairly and as quickly as possible and ensuring that lessons are learned and shared to improve the experience of care.

The Parliamentary and Health Service Ombudsman is a free and independent service, set up by Parliament. Their role is to investigate complaints where individuals feel they have been treated unfairly or have received poor service from the NHS in England. If local resolution is not successful, the complainant can refer their case to the Ombudsman for review. The Ombudsman makes the final decisions regarding the complaints individuals make about the NHS.

3. MKUH Complaints Process

Systems and processes are in place within the Complaints and PALS teams to provide the Trust Board with assurance that:

- All complaints are well managed.
- The learning from complaints is identified and used for improvement.
- The complaints service is accessible, open, and transparent.

Each complaint provides an opportunity for the Trust to learn and introduce improvements in areas that patients, carers, and relatives tell us are important to them when using our services. We understand that handling concerns and complaints effectively matters for people who use our services. Our patients deserve an explanation when things go wrong, and they have a right to know what tangible changes have been made to prevent something similar happening to someone else.

Every complaint is triaged by a senior corporate nurse and the Head of Patient and Family Experience or his/her deputy. This is to ensure an appropriate investigation into the issues raised is undertaken and any potential safeguarding concerns are identified immediately and acted upon.

The remit of PALS is to provide advice and information and deal with informal complaints and to provide guidance on how to make a formal complaint, if requested. The team administrate the investigative process for any matters of concern that may have caused low or no harm and focus on resolving issues without the need for a formal process. If concerns are regarding current or treatment that has taken place very recently action should be taken to resolve the issues as soon as possible to ensure the person goes on to have a good experience. Not every complaint needs to be resolved by an in-depth investigation.

Complaints that are more complex and raise issues that may have caused serious or moderate harm require a formal investigation. Formal complaints are administrated by the Complaints team and an investigation is undertaken by the relevant senior clinical staff/manager.

The Complaints and PALS team aim to provide a person-centred approach to all comments, compliments, concerns, and complaints. The Trust actively encourage staff closest to the care and services being received to deal with concerns and problems as they arise. This is to ensure that issues are remedied quickly, and the Trust can be responsive to individual needs and circumstances to improve the experience of the patient. Such timely intervention can prevent an escalation of a complaint and achieve a more satisfactory outcome for all involved. The Trust encourages concerns and complaints and ensures that any lessons learnt are shared throughout the Trust and this information is used to inform service improvements for our patients and public.

When dealing with complaints, the principles, as laid down by the Parliamentary Health Service Ombudsman (PHSO), should be taken into consideration and adhered to. The principles are as follows:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

Most importantly, the Trust should put the complainant at the centre of process and ensure that the complaint is dealt with in the way the complainant wishes, wherever possible. The Trust should not decide on behalf of the complainant how the complaint will be processed, and the decision should be made in conjunction with the complainant.

4. Annual Complaint Figures

MKUH is organised into four core divisions, these are Surgical Services, Medical Services, Women and Children's Services, and Core Clinical Services. Each division

is led by a triumvirate team which incorporates a Divisional Director, Chief Divisional Nurse, and an Associate Director of Operations, who are collectively supported by Corporate Services.

The complaint numbers during 2022/23 have been collated for each division and the number and type of complaints received has been closely monitored and analysed to identify themes and trends to inform future improvements moving forward.

A total of 1146 **complaints** (formal and informal) were received by the Trust during 2022/23, as detailed on the chart below, this an increase from 2021/22 of 9.8% (n=1044). The number of formal complaints totalled 164 and informal complaints 982.

	Q1 Apr - Jun 22	**Q2 Jul – Sep 22**	**Q3 Oct – Dec 22**	**Q4 Jan – Mar 23**	**TOTAL**
Complaint Numbers	267	238	329	312	1146 complaints (n = 1044 2021/22 **increase 9.8%**)

National complaint regulations state that any concern resolved within 24 hours does not have to be reported as a complaint. Resolving concerns and issues in a timely manner ensures that the patient/family can move on to have a better experience.

A key performance indicator (KPI) was assigned to the PALS team to achieve resolution of 30% of the concerns raised within 24 hours. This KPI was achieved in 2022/23 with a result of 40.7% There was also an increase in the number of concerns resolved within 24 hours when compared to 2021/22, the increase amounted to 20.8% (558 - 2021/22 and 674 2022/23).

The information arising from concerns that are resolved within 24 hours is recorded on the Trust's event reporting database separately to complaints. This ensures that valuable information is retained and used to determine performance and learning across the divisions in relation to all feedback.

5. Responding to complaints

The following definitions are used to provide clarity about whether an issue of concern is handled in line with the NHS complaints procedure and to ensure that the Trust provides the most appropriate response.

Formal Complaint – A formal complaint can be defined as an expression of dissatisfaction with the service provided (or not provided) or the circumstances associated with its provision which requires an investigation and a formal response to promote resolution between the parties concerned.

Informal Complaint – An informal complaint can be defined as a matter of interest, importance or anxiety which can be resolved to the individual's satisfaction within a short period of time without the need for formal investigation and formal

correspondence. Informal complaints are received by staff throughout the organisation. Where it has not been possible to resolve the complaint quickly (i.e., by the end of the next working day) and to the satisfaction of the person raising it, they will be asked if they would like their concern investigated as a formal complaint under the NHS Complaints Regulations (2009). All complaints whether resolved by the next working day or not are recorded and reported on and reviewed, collated, and analysed on a local basis.

It is important that complaints are handled in accordance with the needs of the individual case and investigated fairly and proportionately.

The Trust follows the Department of Health guidance and legislation (the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009) which outline the requirement to acknowledge all complaints within three working days. Under current legislation Trusts have six months in which to resolve a complaint to the satisfaction of the complainant providing a more flexible agreement with each complainant. MKUH aims to provide a response in as timely a manner as possible and work to an internal benchmark of 30 working days or 60 working days for complaints graded as Red (severe harm).

To ensure that people feel safe and supported to make a complaint, everyone is directed to additional information, advice, and advocacy support. Complainants are also signposted to the Parliamentary and Health Service Ombudsman (PHSO) (stage 2 of the NHS complaints process) where they remain dissatisfied with the results of the Trust's investigation and complaint handling.

All complaints are dealt with in line with the Trust's complaints policy which includes an initial triage process to ensure complaints are investigated at the appropriate level and in a timeframe considering the severity of harm. Each complainant is given the opportunity to speak directly to the Complaints or PALS team to discuss their complaint in further detail to ensure expectations can be met. This process ensures absolute clarity on the issues to be addressed and confirms what the complainant wants to achieve as an outcome from the process, along with how they would like to receive their response, in writing or a meeting with responsible medical staff, or both.

6. Complaints referred to the Parliamentary Health Service Ombudsman

During 2022/23, 8 cases were referred to the PHSO as follows.

Total cases referred to the PHSO	Number of cases awaiting investigation by the PHSO	Number of cases where recommendation(s) made	Number of cases where the PHSO deemed there was no case to answer
8	7	0	1

There were 2 cases referred to the PHSO during 2021/2022, and where recommendations were made during 2022/23. Below are the detailed recommendations and the action taken.

Division	Details of recommendation	Action taken
Surgery Division and Medicine Division	Recommendations were made for the Trust to review the systems of communication between the Emergency Department and the Trauma and Orthopaedics team and create an action plan about how it shall better review and communicate x-ray findings to other departments.	Action plan and standard operating procedure (SOP) developed by both the Emergency Department and the Trauma and Orthopaedic team. Reference: SOP Title: Managing Investigation Results in the Emergency Department
Medicine Division	In line with “principles for remedy”, a recommendation was made asking the Trust to apologise to the family for the distress caused by not following up after their complaint resolution meeting. Additionally, apologies should be offered for a missing dose of antibiotics. The Trust should ascertain why this happened and put measures in place to prevent it from happening again.	The Cardiology team led on sharing lessons learnt around antibiotic administration, and careful documentation around missed doses, including the reason why and alternative treatment. Letter of apology shared with the complainant.

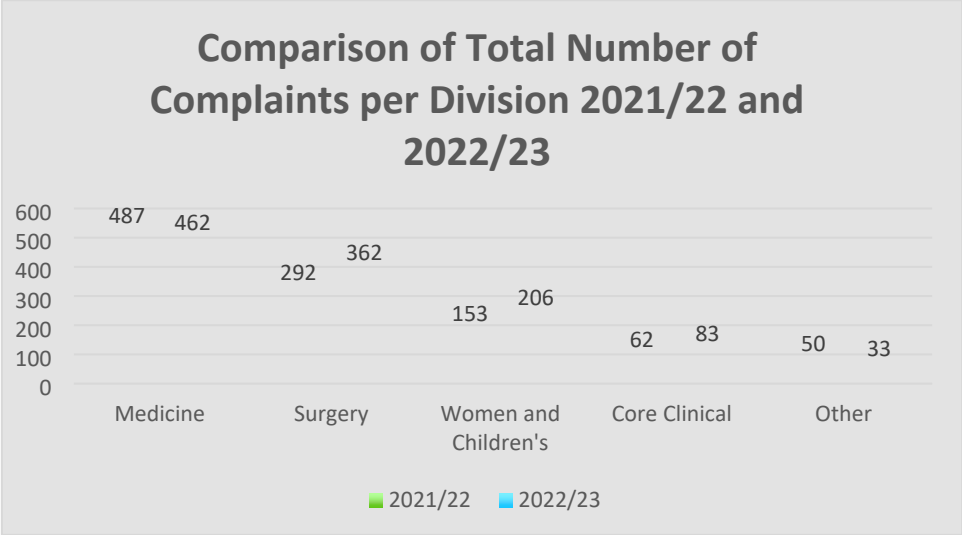
7. Complaint statistics

The 1146 complaints received in 2022/23 were represented across all divisions.

Complaints by division

The chart below compares the number of complaints received for the four main divisions for 2021/22 and 2022/23.

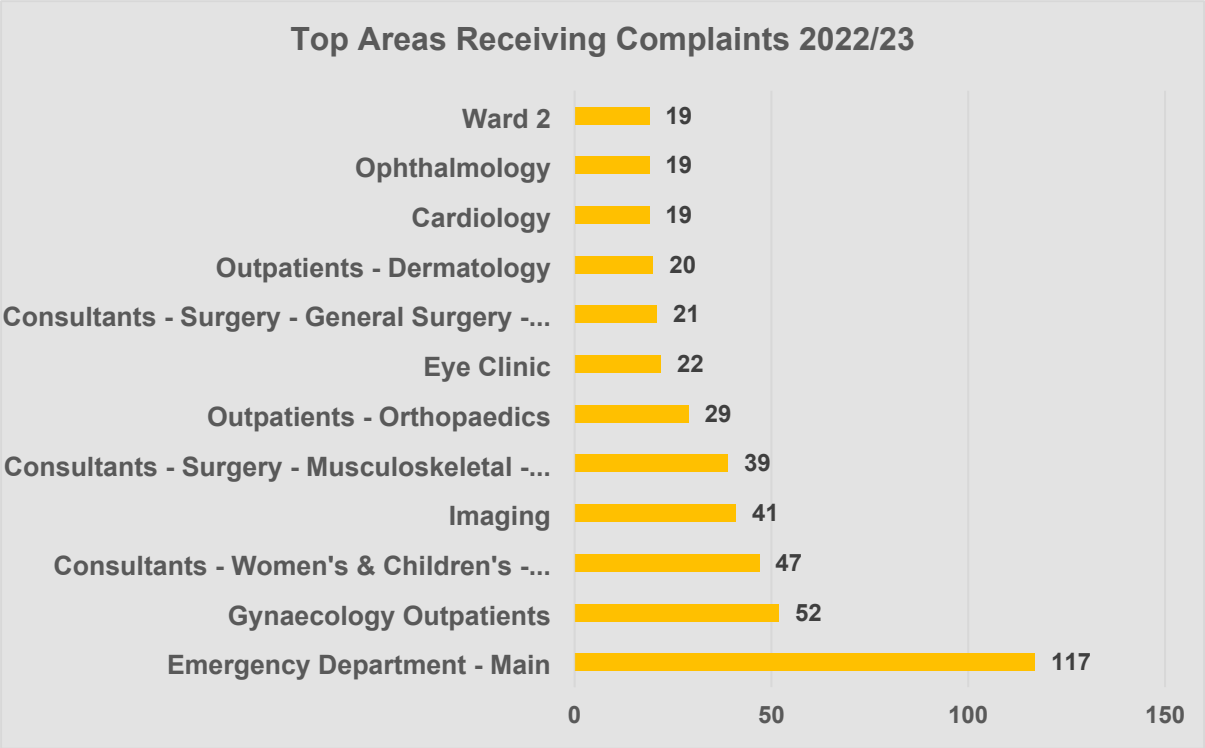
Chart 1 – Comparison of total number of complaints per division 2021/22 and 2022/23



8. Complaints by area

The chart below details the top 10 areas receiving complaints in 2022/23.

Chart 2 -Top 10 Complaint areas for all complaints 2022/23



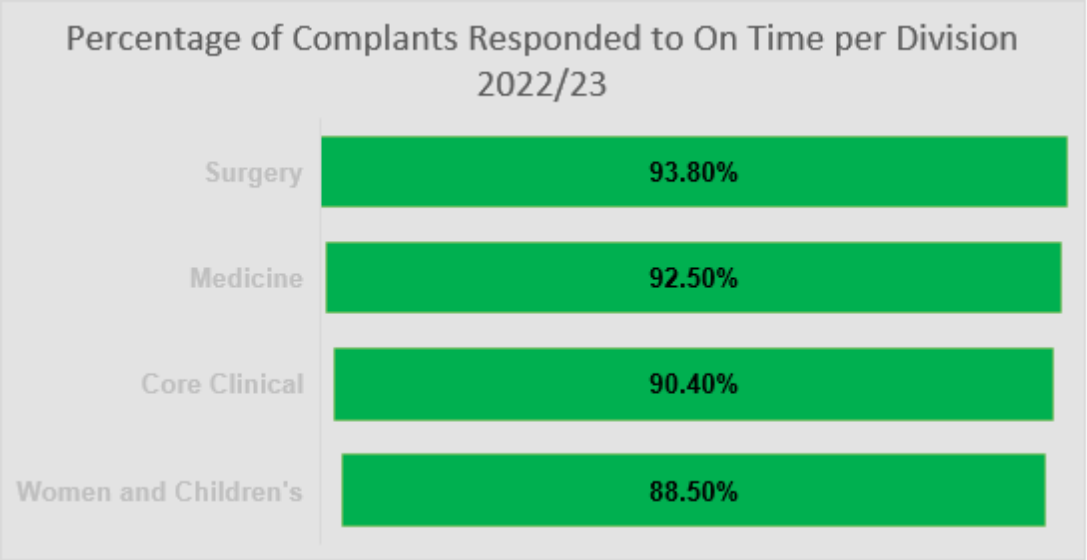
9. Responding

Each triaged category has agreed Trust timescales in which a response to the complainant should be made, as follows:

Green and Yellow (No and Low Harm):	15 Working Days
Amber (Moderate Harm):	30 Working Days
Red (Severe Harm):	60 Working Days

The chart below details the number of complaints responded to on time per division in percentage terms for 2022/23

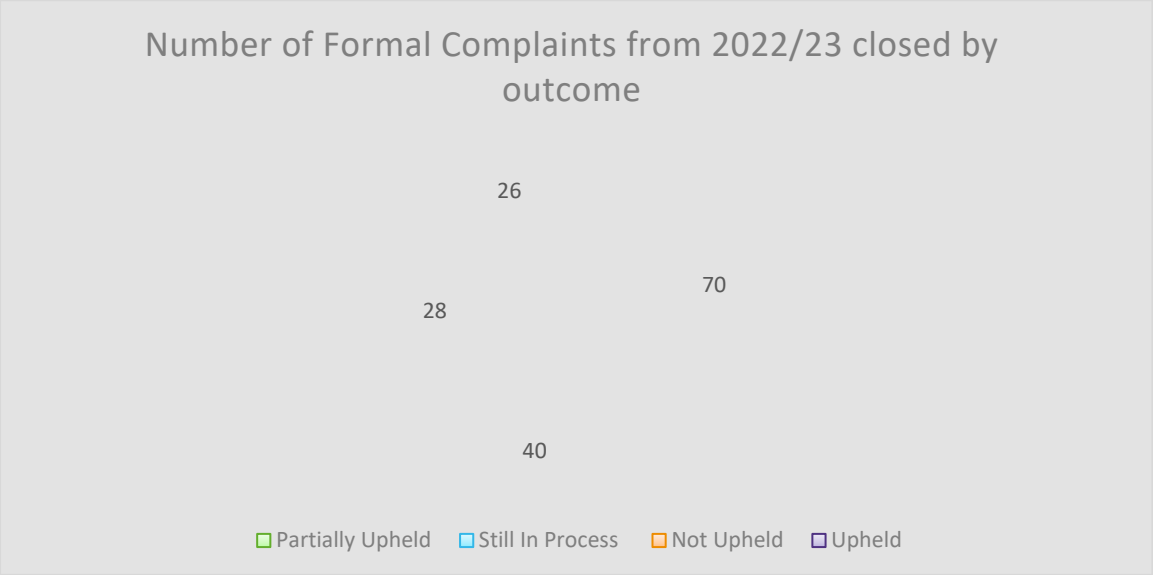
Chart 4 – Complaints responded to on time per division in percentage terms 2022/23



10. Complaints by outcome

Once a formal complaint investigation is complete, it can be determined whether the complaint is upheld in its entirety, partially upheld, or not upheld. The chart below shows the number of moderate harm (Amber) complaints upheld, partially upheld, or not upheld during 2022/23**.** During this period there were 164 Amber complaints of which 40 are still in process at the time of writing this report.

Chart 5 – Closed Formal Complaints Outcome for 2022/23



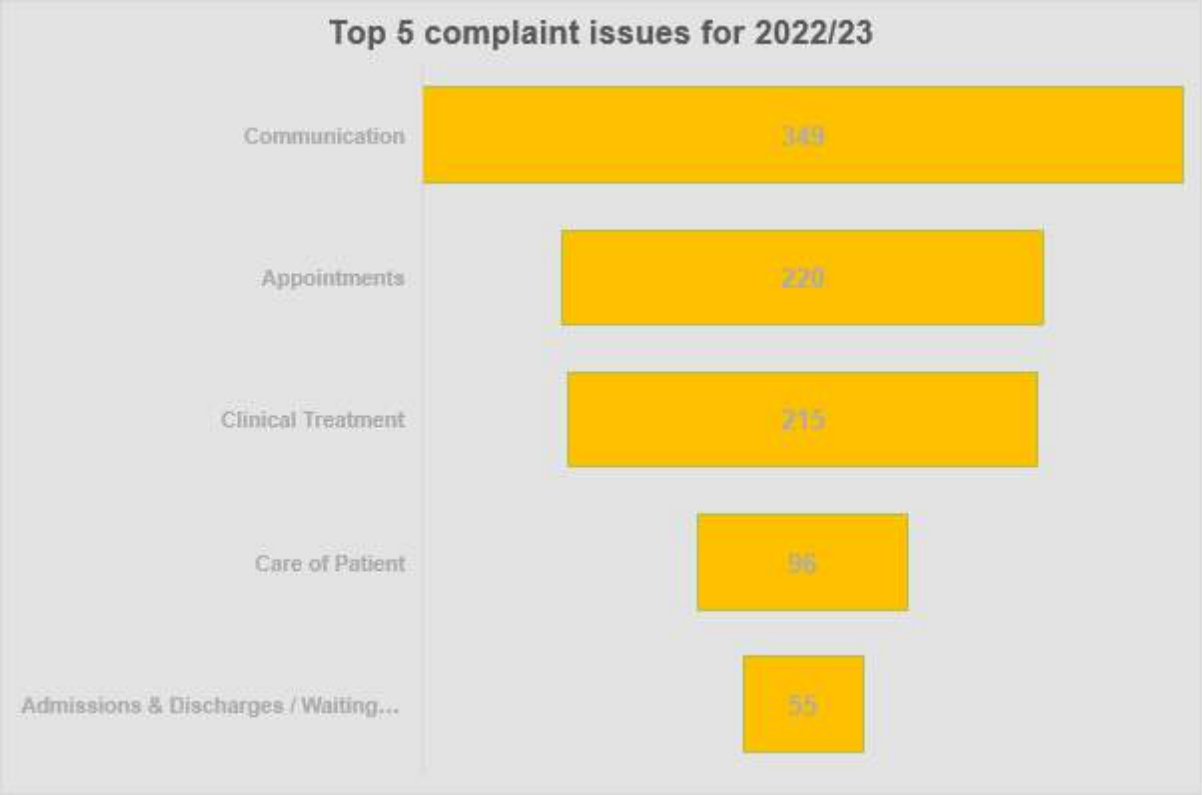
11. Category of Complaints

Complaints are recorded and categorised to help the organisation identify themes and trends and identify improvement actions in response to the findings.

Each issue reported in a complaint is logged onto the event reporting database, now Radar, using the category it pertains to. Some complaints have more than 1 issue and to ensure a true reflection of all issues encountered all issues are recorded.

The chart below shows the top 5 issues raised in complaints for 2022/23.

Chart 6 –Top 5 Complaint Issues for 2022/23



Communication and appointment issues are the most complained about issues in all complaints for 2022/23.

During a complaint investigation if issues of a serious nature come to light, the appropriate clinical leader for the Trust i.e., Chief Nurse or Medical Director are made aware, and their advice sought.

12. Internal monitoring

The numbers and issues raised in complaints are shared with the Board in quarterly Complaints and PALS reports.

Governance Groups are provided with a summary of complaints for each CSU by their Clinical Governance Lead. The summary encompasses details of complaints received by individual service.

13. Reopens

If a complainant remains unhappy with the response to their complaint, they are encouraged to return to the Trust with their outstanding issues. These files are

reopened and further investigation, if required, takes place with the final resolution taking the form of a meeting with the complainant or a further written response. The re-opening of a file takes place to enable the Trust to understand why a complainant is unhappy with their initial complaint response and to ensure that any outstanding issues are dealt with in a timely manner and this performance can be measured.

The number of formal complaints that have been reopened for further investigation during the period form 1st April 2022 to 30th March 2023*, when 1146 complaints were received, was 14 (1.22%).

*Radar is unable to provide this information currently, and the number of reopened formal complaints is therefore calculated manually.

14. PALS activity

The PALS team deal with calls from patients and the public requesting information, advice, or the need of signposting to a different organisation or department.

The number of contacts in this respect, for the year 2022/23, with a comparison for previous years, is shown below.

	2018/19	2019/20	2020/21	2021/22	2022/23
Feedback/Improvement suggestions	112	62	66	28	37
Information	1262	1134	735	563	1216
Signposting	710	814	557	355	624
Total	2084	2010	1358	946	1877

15. Lessons learned, and actions taken from complaints

The Trust values the opportunity that each complaint brings to learn and improve and recognises the importance of sharing the learning from complaints across the organisation for the benefit of our patients and their families and staff. We continue to strive to demonstrate the changes that have been made as a result of the learning from complaints and to sustain the changes for long term improvement.

The Trust acts on feedback to make improvements to its services wherever possible. Details of lessons learned, and actions taken are inputted on the Trust's event reporting database. Every action mentioned in the response to the complainant is allocated for completion to the responsible member of staff.

There have been many actions for complaints this year across the CSU's including:

Medicine:

Dissemination of lessons learnt and shared learning across team:

The complainant said:	The improvement/action was:
A patient was discharged from the Emergency Department with a cannula still in place.	The complaint was shared and discussed with Emergency Department managers, to reiterate the importance of ensuring that all discharge processes are followed correctly, including the removal of cannulas.
That they wished to understand why an injury to their shoulder had not been identified, when they attended the Emergency Department.	Complaint used as a case study for clinical learning within the department, reiterating the need for a thorough examination with a specific focus on distracting injuries that can mask further injury.

Staffing:

- Matrons are now rostered to work night shifts to provide senior leadership during the night, and to reiterate expectations and standards of care to night staff.

- Substantive leadership introduced on escalation areas, where the division are seeing complaints raised. Working with the Therapy teams wrapping around care on the escalation areas.

Process review:

- Appointment schedules, including those rebooked and cancelled, are being scrutinised by the Operational team to identify any possible reductions in this happening for patients.

Surgery:

Change in clinical practice:

The complainant said:	The improvement/action was:
That the clip used to mark the area during a mastectomy procedure was not located and removed.	It was not standard practice to localise the clips for mastectomy specimens, and since receiving this complaint the team have requested that an x-ray of specimens is undertaken to ensure that the clips are included.

Information provision:

The complainant said:	The improvement/action was:
That when a stoma was fitted, they did not have access to the support and information they needed.	Patient information and support has been reviewed and improved with the Stoma care nurses providing advice and training to staff.

Communication:

The complainant said:	The improvement/action was:
That they were unable to get adequate updates from a senior nurse about the care of their loved one.	Introduction of protected time for relatives to meet with the Senior Sister/Charge Nurse to discuss any concerns or feedback they may have.

Staffing:

- Matrons are now rostered to work night shifts to provide senior leadership during the night, and to reiterate expectations and standards of care.

Women and Children:

Staff training:

The complainant said:	The improvement/action was:
That they were left feeling worried and concerned unnecessarily as they were given incorrect information about the antenatal screening programme.	Community midwives undertook training with the antenatal screening team, during their protected training afternoon, to discuss the screening pathway. The leaflets included in the information pack have also been reviewed and replenished.
That staff did not provide appropriate support with breast feeding.	The continuation of two-day training for all new staff joining the Maternity team. Regular updates shared with staff regarding ongoing breastfeeding training. Welcoming back of breast-feeding support volunteers on the ward.

Process review:

The complainant said:	The improvement/action was:
That the availability and the communication around the option for women to use Entonox as pain	An Entonox management standard operating procedure has now been completed for maternity. This includes

management whilst on the ward should be reviewed.	Entonox use on the ward. This will be added to the Trust's internet page to support women to make informed decisions about their care.
That there appeared to be no clear pathway for communicating tests results to families. This led to a delay in the family being made aware of treatment plans or next steps.	The Paediatric consultant team have led on implementing a new process, which ensures test results are shared consistently and in a timely way.
That it was confusing when booking appointments at the beginning of pregnancy.	Operational teams supporting with streamlining process for making booking appointments when receiving self-referrals for maternity care, reducing the delay in an appointment being made.

Communication:

- Meet the team events are ongoing, with service users being invited to meet different professionals they may meet during their pregnancy.
- New birthing beds installed in Labour Ward.

Core Clinical:

Process review:

The complainant said:	The improvement/action was:
That the review and assessment undertaken by the Dietetic team was delayed due to the failings of the referral system.	The process for referrals has been reviewed and changed. All urgent referrals are now automatically booked into a gastroenterology clinic as urgent appointments.

15. Conclusion

It is the responsibility of all staff to deal with any complaint or concern that is brought to their attention. If the member of staff is not able to deal with the issue, then they must escalate this to their manager. Patients and their families should never be discouraged from making a complaint and information on how to make a complaint is available on the Trust's internet site and in the complaints and PALS leaflets and through PALS and available on all ward areas/departments.

The complaints process used at MKUH is aligned to local policy and national regulations and guidance and, as such, all complaints are encouraged and dealt with in a timely manner with an appropriate response being given. The themes and trends

from complaints are considered when setting the priorities for the Trust in relation to patient experience.

Meeting Title	**Trust Board of Directors**	**Date: 02 November 2023**
Report Title	**Trust-wide Report – Annual Patient and Family Experience Report**	**Agenda Item Number: 13**
Lead Director	Kate Jarman, Director of Corporate Affairs	
Report Author	Julie Goodman, Head of Patient and Family Experience	

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

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

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

1. Introduction and purpose

This report details the Trust's overall position regarding patient and family experience feedback, engagement activity and the achievements of the Patient and Family Experience team for 2022/23.

The purpose of this report is to inform the Trust of feedback received from our patients and their families through a variety of feedback mechanisms. The aim is to identify areas of good practice and areas that require support to improve their patient and family experience.

2. Achievements of the Patient and Family Experience team in 2022/23

Increasing the amount of Friends and Family Test (FFT) feedback

During 2021/22, the Patient and Family Experience team worked with the providers of the 'My Care' application, Zesty, to increase the amount of feedback received through the FFT route. This involved Zesty sending the FFT questionnaire to patients via a SMS message.

Following the success of this service in Outpatients and the Emergency Department in 2021/22, the team launched an option for patients, who have had an inpatient stay of one night or more, to complete their FFT feedback via SMS messaging. Maternity patients are also able to respond to the FFT via SMS. Patients will only be contacted via SMS if they are aged 18 years and over. The launch took place on the 1st August 2022.

For context, please see table below detailing the comparison in number of inpatient FFT responses received this year compared to 2021/22.

Q1 2021/22	**Q2 2021/22**	**Q3 2021/22**	**Q4 2021/22**	**TOTAL NUMBER RESPONSES FOR 2021/22**
1716	1362	1377	972	5427
Q1 2022/23	**Q2 2022/23**	**Q3 2022/23**	**Q4 2022/23**	**TOTAL NUMBER RESPONSES FOR 2022/23**
1366	2150	2522	3503	9541

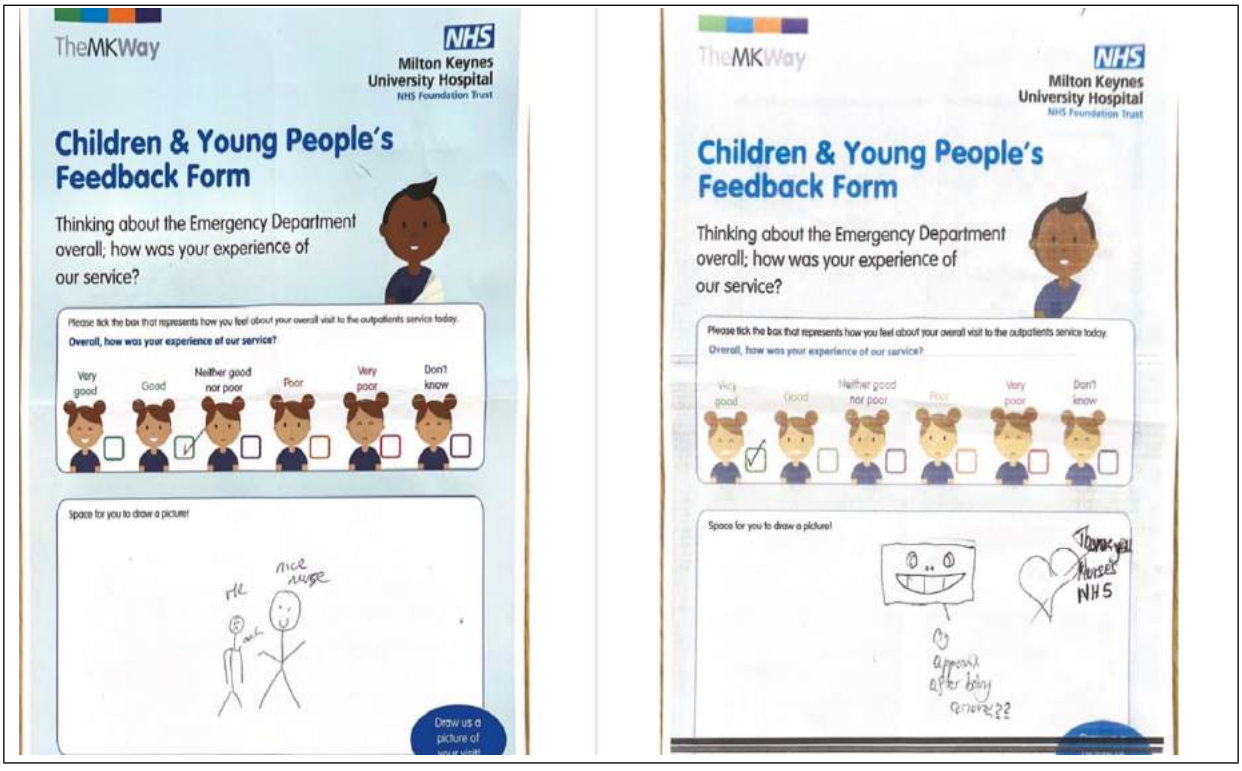
The SMS option cannot currently be used for patients under the age of 18 years. The team are therefore exploring different options to increase the FFT feedback received from our younger patients. The Paediatric ED team have developed a display within the area to encourage patients and their families to share their feedback and the Patient and Family Experience team continue to support the Paediatric team to gain feedback from our patients under the age of 18 years, as follows:

- The relaunch of paper FFT forms for all paediatric areas. The forms are directed towards younger patients allowing them to draw a picture to describe their experience as well as providing the standard FFT questions.

- Supporting Ward 4, Ward 5, NNU, and Milton Mouse Unit to order Friends and Family display boards to display feedback received and for parents and children to write their feedback on. The boards also provide a QR code link to complete the FFT online.

- Wards 4 and 5 now have a QR code poster on bedsides and other areas linking to the FFT survey to allow easy access for patients and families to share their experiences.

- Supporting the Paediatric Emergency Department (PED) to increase the amount of feedback received. The PED Senior Sister has offered a variety of initiatives to her staff to increase the amount of feedback they gather and, as a result, feedback has increased.



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Patient Experience Resource Trolley

The Patient Experience Resource Trolley, Buddy, is now making an appearance on ward areas with the support our patient experience volunteers.

Buddy contains 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. The hospital charity has supported the team with items for Buddy.

The Buddy rounds also provide an opportunity for a conversation with patients and their families to gain their feedback and ensure their experience is positive.

Feedback received from staff and patients regarding Buddy has been extremely positive. The team will continue to recruit further volunteers to enable Buddy to eventually be out on the wards every day.

The following is a quote from a patient:

'Very friendly staff. The ladies with the trolley were very lovely and gave me a few things, a colouring book, pens, toiletries. All donated and free as had nothing with me. Had a lovely chat as well.'

Mobile Phone Charging Unit for ED

With the support of the hospital Charity, a contract has been entered into with a company, called Joos, who have supplied a mobile phone charging unit for the ED. This will allow patients and families to make sure their mobile phones remain charged. There is a small charge to the user for this service and the Charity will benefit from a small percentage of the income. The success of the project will determine if further charging units will be put in place in key locations across the Trust.

Courtyard

The team is working with the hospital Charity and Arts for Health MK to provide a sensory courtyard for patients, families, and staff. Groundwork and planning are currently taking place. This will be a space for all to use and the Meaningful Activities Facilitator will be planning some outdoor activities, for patients, to make use of the space.

Sign Live

The team are currently working towards providing the SignLive service for our patients that use BSL. The online video service will be accessible via iPads on mobile stands. The hospital Charity has donated 10 iPads for this project which can be used in various locations throughout the Trust. SignLive is an on demand BSL interpreting service. The project is currently ongoing with the involvement of the Communications team and the IT department. The next step is engagement with BSL users to ensure the hospital provides the support that is needed to make this project a success.

New Build Engagement

It was the team's objective, this year, to engage with all patient groups to ensure all views are listened to and considered when the Trust is undertaking new developments/projects/changes to services.

Engagement work commenced in August 2022 when various diverse groups attended sessions to hear of the plans for the proposed new women and children's hospital and surgical block.

The team assisted the New Builds project team in running five sessions for patients/families and the public to learn of the proposed building plans. The aim of the sessions was to gain feedback on what patients/families and the public would like to see in a new build i.e., how they would like it to feel, what could be considered to enable them to have a good experience i.e., decoration, smell, lighting etc.

As the projects develop, engagement will continue to ensure the views of all groups are taken into consideration.

Working with teams across the Trust, engagement with patients and families continues with outreach work being undertaken with patients and families from diverse backgrounds including BAME, learning disabilities and hearing loss groups.

Patient Experience Platform (PEP) Health

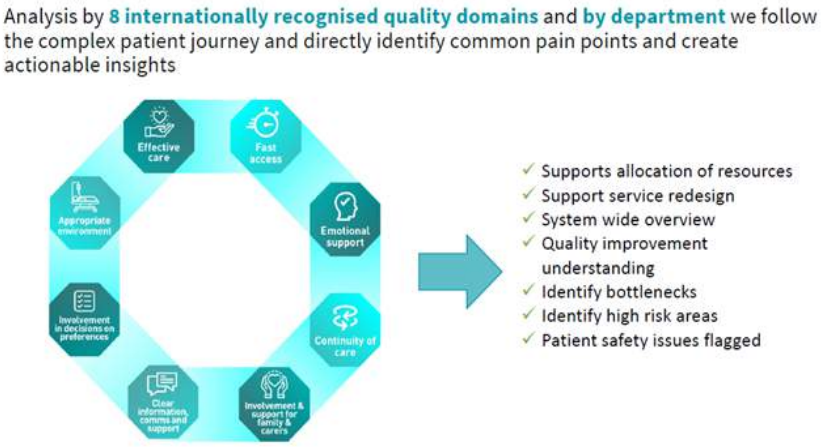
With the increase in the amount of free text comments received through the FFT route it was recognised that theming the feedback inhouse was complex. Analysis that could be shared with the divisions and individual areas to assist them in understanding what the patients thought about their experience,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

On 1st December 2021, collaborative work commenced with PEP Health and the PEP platform (dashboard) was introduced into the organisation.

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

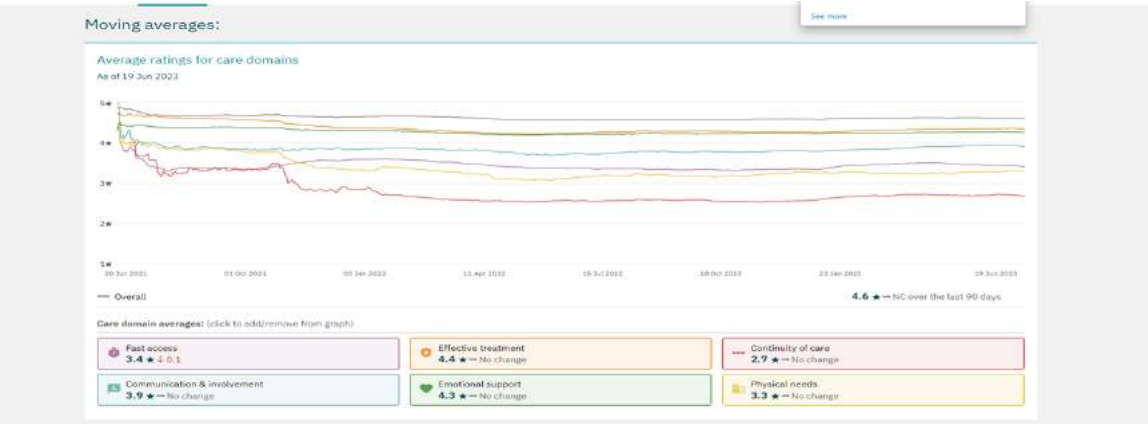
PEP Health use their unique software package to theme the comments into eight quality domains. The comments and themes are available on a dashboard and can be filtered by date, theme, and division or individual service. The platform therefore offers the Trust a unique insight into patient experience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

As above, the feedback is themed into 8 quality domains as illustrated below.



All staff can have access to the dashboard following a request for log in details. Users can select collated feedback from specific areas and timeframes and search for themes using the dashboard via an icon on their desktop. This gives users a more comprehensive range of data than has previously been available.

The presentation of the dashboard is illustrated below:



The team continues to collaborate with PEP Health to ensure staff are accessing the platform.

Q&A sessions and live online training, with the PEP Health team, have been available throughout the year to support staff in understanding how to use the dashboard and review the feedback from their particular area and make comparisons to other areas.

During Q3 2022/23, PEP Health improved the dashboard following feedback and consultation with Trust staff.

Below is a short summary of the features that have been introduced:

- A new home screen that can be customised with an individual ward/team's results which also allows for results to be accessed quickly.
- A 'benchmarking' section for comparing results data from public comments with regional/national averages and neighbouring Trusts.
- An 'internal data' section for looking up Friends and Family test results (FFT)/compliment data for specific units within the Trust. This includes an individual results page for each ward/division/service, as well as an overall comparison page for each category.
- The filters on the comments page have been redesigned making it easier to search and filter comments using a range of factors.
- A downloadable monthly PDF report, detailing results for the whole Trust, is now available on the home screen.
- Under the current themed care domains, a further breakdown of themes into sub domains will be available which will allow for a greater understanding of the feedback.
- Work is ongoing to support the production of a weekly or monthly report that will be sent direct to users' inboxes without the need for them to log in to the dashboard.

These updates have been shared with staff. The team continue to work with PEP Health to continuously develop the dashboard and encourage staff engagement to ensure there is shared learning and improvement, as a result of the feedback received.

The team continue to support Trust staff to access and use the platform and encourage using the data to improve patient experience. During Quarter 1 2023/24, a day will be dedicated to the further promotion of the PEP dashboard by visiting the ward areas with the CEO from PEP Health. During these visits the dashboard will be demonstrated, and the team will be looking for junior staff within ward areas to become champions for the use of the dashboard.

During quarter 1 2023/24, the team will work in collaboration with PEP Health to enter various national awards around using technology to improve patient experience.

Compliment Project

All written compliments are acknowledged and shared with individual staff and their managers. During this year, as above, the PEP Health dashboard has been

developed to capture the comments from compliments and these are themed in the same way as the Friends and Family Test comments.

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

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



Alongside the card/certificate a golden raffle ticket is given for a draw that takes place every quarter, with the winner receiving a £25 Amazon gift voucher, the winning ticket is picked at random.

During 2022/23, the £25 Amazon vouchers were won by the following staff:

Q1 – Ward 14

Q2 - Willie Zapanta

Q3 – Ward 2a

Q4 - Security Team

QR Code Project

Since November 2022, QR codes have been displayed on patients’ bedside cabinets. The QR code directs patients and their families to a dedicated ward information page which details any information they may need to know i.e., visiting times, who’s who from a uniform perspective, how to access snacks/drinks etc. The information pages were put together following consultation with patients and staff.

Being able to access information from one single source will enhance the experience of our patients and families, ensuring they can easily access the important

information that they need, and which makes so much difference to their experience.

The project was widely advertised through various communications channels to ensure all staff were aware of the initiative to enable them to share the benefits of this with their patients. The project will be ongoing and reviewed by gaining feedback from patients.

Patient Experience Week

During the week commencing 25th April 2022, the team celebrated Patient Experience Week. This was time to celebrate accomplishments, re-energise efforts, and recognise the ways in which staff, their kind words, and their dedication, immeasurably improve the experience of our patients.

In the week leading up to Patient Experience Week, the team visited staff throughout the organisation to thank them for the difference they make to our patients and their families, every day. With the support of the Communications Team a video recording was made in celebration of our staff. The link to the video is below:

https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmkuhcloud.sharepoint.com%2F%3Av%3A%2Fs%2FCommunications%2FEefQT1xPyo9KlJUxGhYcbYUBG3CBodkVxSOihjad4VS_cw%3Fe%3D4%253akCuMXP%26at%3D9&data=05%7C01%7CLisa.Barnes%40mkuh.nhs.uk%7C6e4dc29ba9474db3572d08da26a3b851%7Ce96dd0a15d474a949e4a5c1056daa82c%7C0%7C0%7C637864781850375893%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=iSbnd%2FAYgiihHh2EefHxSSzrybwcOjhP4%2B9wZclsUAI%3D&reserved=0

A competition was also held to name the Patient Experience trolley. The winning name was ‘Buddy’.

Carers Week

The team helped celebrate Carers Week during the week commencing 6th June 2022. This was an opportunity to celebrate the role carers play in looking after their loved ones. An event held by Carers MK, in the community, was attended by the team to meet with carers, listen to their experiences, and discuss forthcoming engagement work and opportunities.

During this week the team collaborated with the Trust’s Catering Manager to celebrate our local carers, adults, and children, by treating them to afternoon tea. The Trust’s Meaningful Activities Co-ordinator also attended and undertook some activities with the carers, including blackout poetry and quilling. This was also an opportunity for the Catering Manager to showcase his concept of a patient and family tearoom in the hospital. To enable this concept to come to fruition a space is needed within the hospital where a permanent tearoom could be situated, and families could book a tea and bring their loved ones to give them some time away from the ward area. All attendees enjoyed their tea and supported the need for a tearoom and had some good suggestions for how the room should look.

Using Appreciative Inquiry (AI) in patient and family experience

The Patient and Family Experience team have worked closely with the AI team to achieve the following:

- Co-created a booklet with patient representatives from the Trust's Patient Engagement Group to use when recruiting patient and volunteers to become patient representatives to support the Trust with advice and feedback, from their perspective, on initiatives and service changes or redesign. The booklet is designed to be completed by the patient or volunteer to enable them to focus on why they wish to engage and contribute to the Trust and what they can bring to the role. Consideration is also given to what would be required from the Trust to ensure a positive and worthwhile experience for all.
- The co-creation with the AI team of a Patient Experience toolkit. An online toolkit which includes selection of tools and resources to support Trust staff to gather and learn from patient experience stories. It includes a range of tools and resources that can be used to gather stories and feedback, ideas for using the Friends and Family Test (FFT) and compliments to grow and develop as a team, and a framework for personal and group reflection for responding to patient and family concerns.
- AI tools were used by Trust staff to obtain high quality patient feedback. The tools challenge staff to think about the language they use during patient interactions to consider what really matters to our patients and their families and therefore what changes can be made to improve experience.
- Participation in the Festival of Conversation and Curiosity. This festival explored those experiences and conversations that help us to learn what is important to people and what they value. During the festival, ways of 'working and being' were explored, and tools and skills were introduced that can help facilitate these conversations, even when time is short. The team held a stand during the 'walk through wonderland' and the 'mastering the art of curiosity' event. The 'walk through wonderland' event was well attended, and all staff were treated to an ice cream van and free lunch. This was also an opportunity to launch the online Patient and Family Experience Toolkit, as above.
- The PALS meeting room is now used to store and display information and advice in respect of the use of AI tools. Support can be given by request.

Shadowing Programme

The team continue to invite Trust staff to spend time shadowing the various departments within the Patient and Family Experience team, to learn about the different aspects of patient experience. The team offer a formal day long programme that includes an introduction to the Complaints and PALS team, working with the PALS team to take calls etc., reviewing the many ways patients can feedback about their care and how staff can promote this when they go back to their ward/area, and a debrief.

Staff are also welcome to attend a shorter introduction to the team or a period of time dedicated to learning and supporting the PALS team.

Patient Clothing Supply Project

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

This project is two-fold:

1. Making sure patients are suitably dressed whilst in hospital. This is essential for initiatives such as #endpjparalysis and for participating in therapy and functional assessments. Being dressed as they would be in their own home is proven to shorten the length of stay and helps maintain the patient's dignity.
2. Making sure patients are suitably dressed to go home. Age UK have raised concerns about patients being taken home in just a hospital gown, red socks, and a blanket around their shoulders. This feedback has also been received through complaints received.

Developments to date have been:

- Voluntary Services purchased two linen trolleys for the central storage of clothing.
- The Linen Room has provided a dedicated storage area for the clothing.
- The hospital Charity has provided a contact in the community who has provided a large amount of new clothing/coats/shoes.
- Discussions have been undertaken with the hospital Charity to look at a possible Amazon 'wish list' to keep an ongoing supply of the basics needed i.e., slippers, loungewear, and dressing gowns.
- The team are currently producing an inventory of the clothing available.

The project team will continue to meet and will work with the Communications team to ensure all staff are aware of the project and how clothes can be located.

Meaningful Activities Facilitator

The Meaningful Activities Facilitator (MAF) became part of the Patient and Family Experience team during Q2 2022/23. MKUH is fortunate to have this post, we are one of only two Trusts in the country to have this role. The post is currently funded by the MKUH Charity until Spring 2024 and the hope is to make this a permanent role for the future. The aim of the role is to enrich the experience of any adult patient who is perhaps feeling low in mood, having difficulty being in hospital, or needs some encouragement to support their wellbeing.

The Meaningful Activities Facilitator works with all patients, especially those with a dementia diagnosis, or those experiencing a lengthy hospital stay. A range of activities are offered, from painting and clay work to creative group activities. There have been many positive reports on the difference the activities have made to patients.

A younger patient's feedback was as follows: -

'*I would recommend [meaningful activities] as it put me at ease in a stressful environment, and it helped me get through the difficult times as I was learning new things such as different techniques, strokes, and patterns in water colouring painting. This made the time go faster when I was in hospital and I have found another hobby that I didn't realise I would have enjoyed, thank you.'*

During 2022/23, the MAF has supported 245 patients, with a total of 600 dedicated hours providing one on one support or group activities with our patients.

Volunteers have been recruited to support the activities of the MAF currently and 5 meaningful activities volunteers offer weekly support to wards. Ongoing recruitment of volunteers is taking place to enable more wards to be supported. The MAF volunteers offer dedicated time to patients who may need that extra soft-touch support, stimulation, and comfort which perhaps the ward staff do not have the time or resources to offer. The volunteers have completed a total of 46 visits, with two of those volunteers visiting 95 patients. The volunteers hold one to one or group-based activities and companionship to patients on Wards 3, 14, 18, 19, and soon Ward 23.

Feedback from two of the volunteers:

'*Had an amazing day, speaking to so many patients which was really nice! Did some word searches with the first patient. Then me and Pat did some puzzles and just had a good conversation, which was lovely. After, I had a conversation with Olive, which I found very interesting. Also, had a conversation with Audrey about books. Overall, a fun day!'*

'We did puzzles and colouring today, but mainly interested in the puzzles. Patients had a fun 'competition' whilst doing the same jigsaw, very fun experience. On my second day this week, we made some flowers with patients, and two of them had visitors who saw and appreciated the flowers being made too. All enjoyed the challenge of folding the paper and adding letters/ leaves from pipe cleaners.'

The MAF is also re-launching the ward activity boxes, with added items and activities to provide stimulation, relaxation, and well-being, in addition to further communication aids to help the communication between patients and staff. An online 'shop' which is available to the wards via a QR code is now available to enable ward staff to order further supplies for their boxes and any available specific items that are requested by patients. Information regarding the process was shared with staff using a variety of communication tools and will also be detailed on the activity boxes.

Patient Led Assessment of the Care Environment (PLACE) Audit

The team supported the Hotel Services team to undertake the annual PLACE audit. Patients were recruited by the team and individual team members also took part in the sessions. The PLACE audit entails a team of assessors attending wards and departments to review how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness, and general building maintenance and, more recently, the extent to which the environment can support the care of those with dementia or with a disability.

Before the annual inspection, during August and September 2022, teams undertook PLACE lite sessions to ensure familiarity with the requirements of the process and the documentation required. The annual PLACE audit took place on the 30th September 2022. The teams covered 11 wards and all the main departments, as well as tasting and providing feedback on the food service.

This year saw a higher level of patient representation than that of previous years resulting in the most comprehensive PLACE inspection ever.

The Hotel Services team will report the outcome of the PLACE inspection through their own management structure with a report being presented at the Patient and Family Experience Board.

Healthwatch Annual General Meeting (AGM)

Representatives from the Patient and Family Experience team attended the AGM on the 22nd September 2022. Compliments and Friends and Family (FFT) feedback was showcased, and attendees were encouraged to engage in ongoing projects.

Information that will be useful for hospital patients was gained from community groups.

3. Patient Experience data

Friends and Family Test (FFT)

The table below details a comparison of the number of FFT responses received across the Trust for each quarter 2022/23.

Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	TOTAL NUMBER RESPONSES FOR 2021/22
3137	3600	16499	16059	**39295**
Q1 2022/23	**Q2 2022/23**	**Q3 2022/23**	**Q4 2022/23**	**TOTAL NUMBER RESPONSES FOR 2022/23**
12605	13164	11745	15452	**52966**

During 2022/23, 93% of patients on average rated the Trust's services as very good or good.

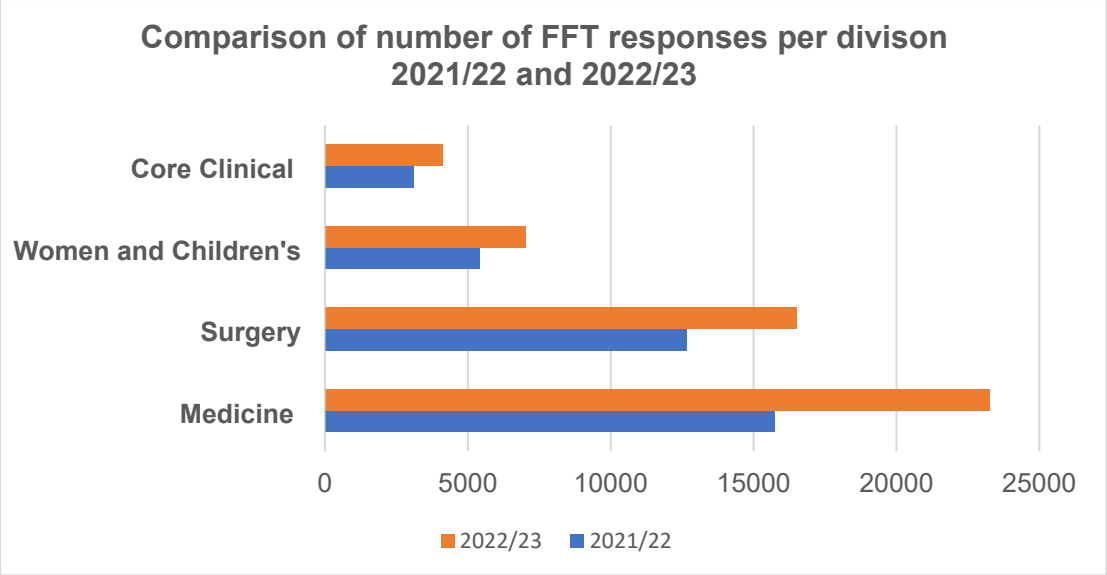
FFT- Ethnicity

From the 52966 respondees to the FFT,and where an ethnic origin was stated, 82.5% of respondees described themselves as being White British.

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

Divisonal FFT responses

The chart below details the number of FFT responses per divison for 2022/23 when compared to 2021/22.



FFT care principles

During 2022/23 the overall rating for the Trust in relation to positive comments from FFT feedback was 4.6* out of 5*.

The Trust are performing **well** in the following care principles according to FFT feedback:

- **Effective treatment delivered by trusted professionals**

Definition: Positive therapeutic relationships between patients and staff are at the heart of person-centred care. People should receive the most appropriate and effective care for their needs and be treated in a way that recognises and respects the outcomes that matter most to them. Interactions with care professionals should inspire a sense of confidence and trust.

- **Emotional support, empathy, and respect**

Definition: To deliver person centred care, a caring holistic approach that includes the provision of support and empathy is needed. For care to be compassionate it must be delivered with respect, dignity, sensitivity and with an understanding about the person.

The care principles in which the Trust are **need improvement** are:

- **Continuity of care**

Definition: Seamless transitions between different providers and staff. Patients experiencing continuity in information, relationships with staff, and management of care.

- **Physical needs**

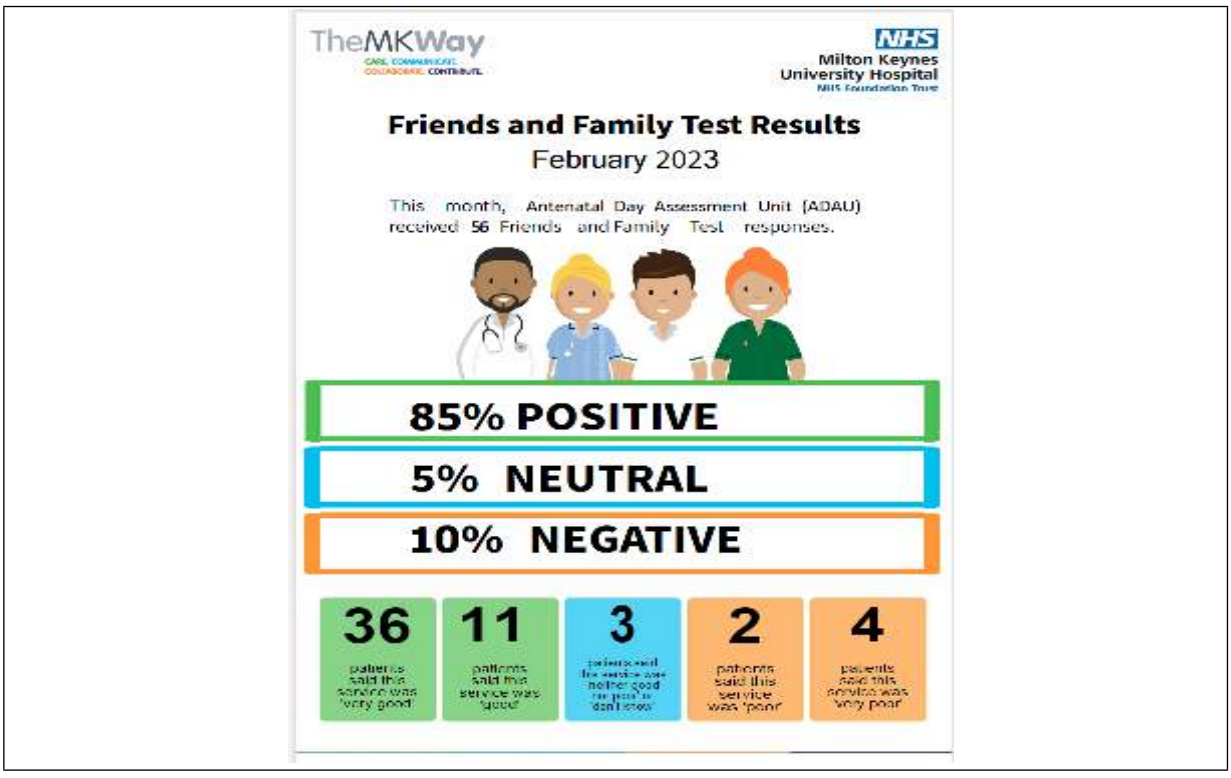
Definition: Providing safe, comfortable environments that afford patients privacy and dignity. Care professionals mindful of people's physical needs and personal care.

Communication of FFT results

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

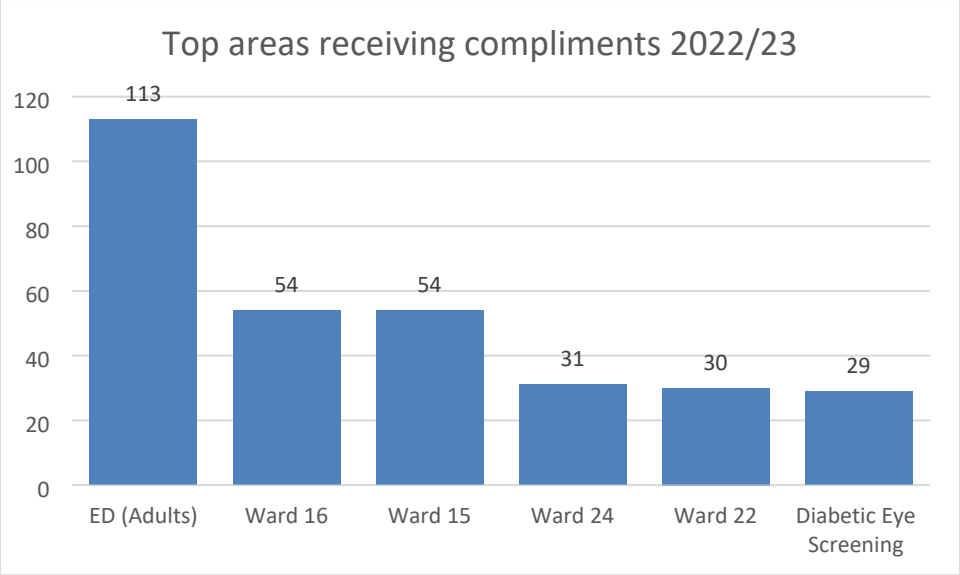
'*Very Good, Good, Neither Good nor Poor, Poor and Very Poor*'

Posters are displayed on all ward areas, as below.



Compliments

During 2022/23 the Trust received 839 compliments, the top areas receiving compliments are detailed in the graph below.

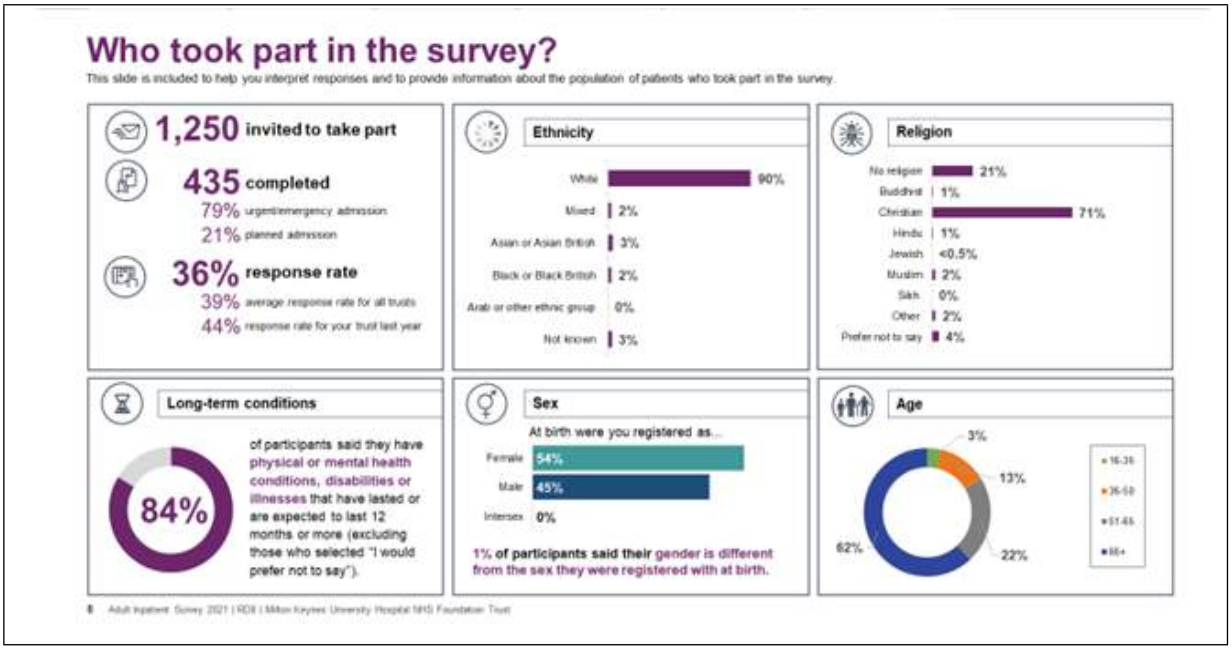


National Surveys

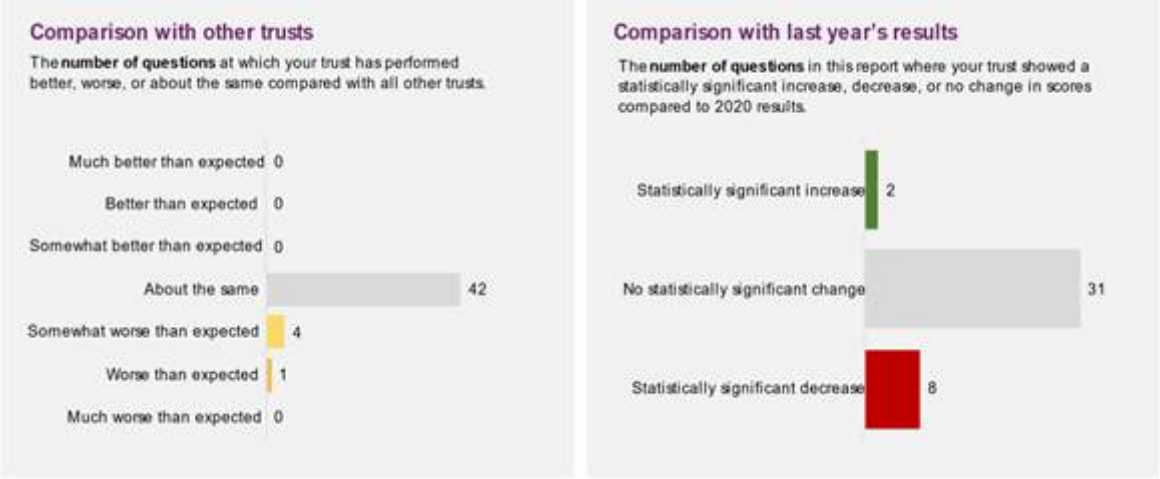
The 2021 Adult Inpatient patient included patients who were admitted and discharged during November 2021. The embargoed results were received in June 2022 from our contractor, Picker, with the official publication of results by the CQC at the end of September 2022.

The highlights from the report are detailed below.

Statistics from the 2021 Inpatient survey



Summary of findings compared with other Trusts



Issues where MKUH were somewhat worse than expected when compared to other Trusts

- Patients were giving contradictory information by staff.
- Patients did not feel they were involved in decisions about their care and treatment.
- Patients were not able to get a member of staff to help them when they needed attention.
- Patients did not always feel they were treated with dignity and respect.

Issues where MKUH were worse than expected when compared to other Trusts

- Patients were not given information on their discharge medication.

Where patient experience is best at MKUH when compared to the average scores of all trusts.

- **Changing wards during the night: staff explaining the reason for patients needing to change wards during the night.**
- **Feedback on care: patients being asked to give their views on the quality of their care.**
- **Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital.**
- **Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital.**
- **Quality of food: patients describing the hospital food as good.**

Where patient experience could improve at MKUH when compared to the average scores of all trusts.

- **Involvement in decisions: staff involving patients in decisions about their care and treatment.**
- **Information about medicines to take at home: patients being given information about medicines they were to take at home.**

- **Getting help from staff: patients being able to get a member of staff to help them when they needed attention.**
- **Communication: patients not being told something by a member of staff that was different to what they had been told by another member of staff**
- **Noise from other patients: patients not being bothered by noise at night from other patients.**

Inpatient Survey 2022

Patients who were an inpatient, for 1 night or more, during November 2022 were invited to complete a survey. The fieldwork for the survey took place early 2023 and the embargoed Picker results are expected in May 2023 with the final CQC report expected August 2023.

ED 2022

The ED survey was sent to patients who attended the ED during September 2022. The results from Picker, the Trust's contractor, are expected in April 2023 and expected to be published by the CQC in September 2023.

Maternity 2022

The Maternity Survey for 2022 has been undertaken and the results have been published. The Maternity team are working in partnership with MVP (Maternity Partnership Voices) MK to draw up an action plan in response to the results.

4. Volunteers

Recruitment

Recruitment of volunteers was recommenced in September 2022, and to date this has resulted in an increase in the number of volunteers in post from 64, post covid, to over 140. Recruitment continues in 2023/24 for more standard ward-based support and dining companion roles.

During 2023/24 more bespoke volunteering roles will be created and further developed such as Meaningful Activities (pictured below), Pastoral Support, Patient Clothes Bank, Outside Yard Support and Outpatient Pharmacy Reception roles.

We have also introduced Pets As Therapy volunteers, who provide pet therapy to our patients. We now have a waiting list of departments who would like a visit!

In conjunction with the Armed Forces Covenant Officer, we have developed a new Armed Forces volunteer role. These volunteers support our veteran patients and provide companionship and comradeship in reminiscing their memories and shared experiences. Les, an Armed Forces volunteer, can be heard sharing his positive experience in supporting a patient.

20230418-MKUH_AF_Les.mov

Volunteer Management System

The Trust has invested in a new Volunteer Management System called Assemble. All volunteers have a user profile and can access this from a PC or mobile device. The Voluntary Services team use the system for management and communication with existing volunteers and the system is also used for recruitment.

Training

Volunteer training packages have moved to an online programme written by Health Education England on e-Learning for Health. This package of learning has been written with a volunteer focus, rather than nursing, as per staff e-learning. In addition to our mandatory training, volunteers can work towards the eLfH Skills for Justice National Volunteer Certificate. This requires volunteers to complete 11 e-courses (8 of which are already completed as mandatory training) together with 60 hours of signed off volunteering service. This has already been undertaken by a handful of existing volunteers, as well as being very popular with new volunteers.

A new interactive Dining Companion training session has been put in place in collaboration with the Frailty nurses. The training includes volunteers being able to try on frailty suits and use impaired vision goggles before trying to complete tasks, as well as an informative session on why we need Dining Companion volunteers. The

training ensures that our volunteers have a greater understanding of the challenges our patients can face. These sessions have been received well.

Butterfly Volunteers in collaboration with the Anne Robson Trust

A new Butterfly Co-ordinator started in post during March 2023. The postholder has started the recruitment of the first cohort of Butterfly volunteers. This special group of volunteers will provide support to patients who are approaching the end of their life and their families /carers. The Butterfly volunteers will attend a full day training course on 4th July 2023 and it is hoped that some Butterfly volunteers will be on wards by the end of July 2023.

Collaboration with MacIntyre Trust and Headway

Collaboration with external learning disability organisations, including MacIntyre Trust and Headway has taken place. The volunteer recruitment processes have been slightly amended to accommodate the needs of the potential volunteers whilst still maintaining a robust recruitment system. Volunteers have undertaken their volunteering role with the support of their case workers, this has ensured they are fully supported whilst volunteering. This opportunity aims to provide work experience in a supportive environment, which will hopefully lead to paid employment in the future.

Relationships are also being developed with local Secondary schools to encourage Health and Social Care students to apply for the Ward Support and Dining Companion volunteer roles to support their studies and future UCAS applications.

Recognition, Appreciate and Celebration events

We recognise that thanking our volunteers is a crucial part of retention and celebrations have been in full swing this year. In March 2023, an Afternoon Tea thank you party took place at a local venue, with nominal gifts and a special guest in the guise of a Jazz Lounge singer providing entertainment, who set the scene beautifully.

Plans are in place for Volunteers Week in June 2023, to issue thank you certificates to every volunteer along with a token gift and a coffee/cake voucher for the restaurant. The Volunteer Long Service Awards will also take place during this time.

5.Governance and learning

Patient and Family Experience Board

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

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

metrics and measures, in alignment with the Trust's overall strategic objectives and core values.

The Patient and Family Experience Board reports to the Clinical Quality Board which in turn reports to the Trust Executive Group (TEG).

The purpose of the Patient and Family Experience Board is to devise, steer, and monitor the progress of actions against the 'Improve Patient Experience' Trust objective.

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

5. Conclusion

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

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

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 02.11.2023**
Report Title	2023-24 Executive Summary M06	**Agenda Item Number: 14**
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 are 8,396 ED attendances in September 2023, an increase of 654 attendances when compared to August 2023.
	- The percentage of attendances admitted, transferred or discharged within 4 hours was 70.0%, a decrease of 3.7% when compared to August 2023.
	- 77.1% of ambulance handovers took less than 30 minutes in September 2023 and 95.7% took less than 60 minutes.
	
	Outpatient Transformation:
	- There were 34,639 outpatient attendances in September 2023, a decrease of 1,042 attendances compared to August 2023.
	- 13.5% of these appointments were attended virtually and 5.7% of patients did not attend their appointment in September 2023.
	
	Elective Recovery:
	- There were 2,341 elective spells in September 2023, an increase of 138 spells from August 2023.
	- At the end of September 2023, 38,870 patients were on an open RTT pathway:
	  o 3,963 patients were waiting over 52 weeks: 328 more than in August 2023.
	  o 954 patients were waiting more than 65 weeks.
	- At the end of September 2023, 10,930 patients were waiting for a diagnostic test. Of these, 62.33% were waiting less than 6 weeks.
	
	Inpatients:
	- Overnight bed occupancy in adult G&A beds was 88.2% during September 2023, within the threshold of 92%. This is a decrease in performance in comparison to August 2023 (87.7%).
	- A considerable proportion of beds were unavailable due to:
	  o 110 super stranded patients (length of stay 21 days or more).
	  o 72 patients not meeting the criteria to reside.
	
	Human Resources:
	- In September 2023:
	  o Substantive staff turnover remained the same at 14.1%, as it was in August 2023, and still above the threshold of 12.5%.
	  o Agency expenditure decreased to 2.5% in September 2023, down from 3.3% in August 2023. It remains below the threshold of 5%.
	  o Appraisals decreased to 90% in September 2023, down from 91% in August 2023. It remains above the 90% threshold.
	  o Mandatory Training has remained the same at 95% as it was in August 2023, remaining above the 90% threshold.

	Patient Safety: - In September 2023, the following infections were reported: o C. Difficile: 3 o E-Coli: 2 o MSSA: 2 o P. aeruginosa bacteraemia: 1 o 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	
Next Steps	
Appendices/ Attachments	ED Performance – Peer Group Comparison

Trust Performance Summary: M06 (September 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	43.7%	92%
4.5a	RTT Patients waiting over 65 weeks	344	0
4.6	Diagnostic Waits <6 weeks	85.2%	99%

To ensure that the continued impact of COVID-19 is reflected, monthly trajectories are in place to ensure that they are reasonable and reflect a realistic level of recovery for the Trust to achieve.

2.0 Operational Performance Targets

September 2023 performance against transitional targets and recovery trajectories:

OBJECTIVE 4 - KEY TARGETS									
ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1a	ED 4 hour target (includes UCS)	76%	76%	73.7%	70.0%	x	▼	x	
4.2	RTT Incomplete Pathways <18 weeks	47.4%	43.7%		38.1%	x	▼		
4.5b	RTT Patients waiting over 65 weeks	0	344		954	x	▼		
4.6	Diagnostic Waits <6 weeks	85.6%	85.2%		62.3%	x	▼		
4.9	62 day standard (Quarterly)	85%	85%		48.7%	x	▼		

The percentage of ED attendances that were admitted, transferred, or discharged within 4 hours was 70%, a 3.7% decrease from August. This was below the national performance of 71.6%, however above the performance of all but one other trust within our Peer Group (see Appendix 1).

The volume of open RTT pathways was 38,870, increasing from 38,731 at the end of August 2023. Of this total, 954 patients had been waiting more than 65 weeks for treatment. The Trust has robust recovery plans in place to support an improvement in RTT performance and to reduce patient waiting times. The cancellation of non-urgent elective activity and treatment for patients on an incomplete RTT pathway is also being proactively managed.

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

In 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 76.7% in the previous quarter.

3.0 Urgent and Emergency Care

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

ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day	1%	1%	0.95%	1.68%	✗	▼	✓	
3.2	Ward Discharges by Midday	25%	25%	14.7%	18.4%	✗	▲	✗	
3.5	Patients not meeting Criteria to Reside	50			72	✗	▲		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)	50			110	✗	▲		
3.9a	Ambulance Handovers <30 mins (%)	95%	95%	78.8%	77.1%	✗	▬	✗	

Cancelled Operations on the Day

In September 2023, there were 40 operations that were cancelled on the day for non-clinical reasons, representing 1.68% of all planned operations. Most of the cancellation reasons were related to insufficient time and availability of theatre staff or beds.

Patients not Meeting Criteria to Reside

The number of inpatients not meeting the criteria to reside at the end of September 2023 was 72 against 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 110.

Ambulance Handovers

In September 2023, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes stayed the same at 77.1%, when compared to last month.

4.0 Elective Pathways

ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight Bed Occupancy - Adult G&A	92%	92%	89.4%	88.2%	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks	47.4%	43.7%		38.1%	✗	▼		
4.4	RTT Total Open Pathways	39,636	41,981		38,870	✓	▼		
4.6	Diagnostic Waits <6 weeks	85.6%	85.2%		62.3%	✗	▼		

Overnight Bed Occupancy

Overnight bed occupancy was 88.2% in September 2023, within the desired 92% threshold.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of September 2023 was 38.1% and the number of patients waiting over 65 weeks was 954. Total RTT open pathways was 38,870.

Diagnostic Waits <6 weeks

At the end of September 2023, performance was 62.3%, declining from 65.2% in August 2023. This was the lowest diagnostic performance that has been reported since April 2022 (61.9%).

5.0 Patient Safety

Infection Control

In September 2023, the following infections were reported:

Infection	Number of Infections
C.Diff	3
E-Coli	2
MSSA	2
P. aeruginosa bacteraemia	1
Klebsiella Spp bacteraemia	1
MRSA bacteraemia	0

ENDS

Appendix 1: ED Performance - Peer Group Comparison

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

July 2023 to September 2023 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Jul-23	Aug-23	Sep-23
Homerton Healthcare NHS Foundation Trust	78.0%	85.9%	79.1%
Milton Keynes University Hospital NHS Foundation Trust	75.3%	73.7%	70.0%
The Hillingdon Hospitals NHS Foundation Trust	72.6%	69.6%	69.9%
Buckinghamshire Healthcare NHS Trust	72.8%	73.9%	69.8%
Mersey and West Lancashire Teaching Hospital (Formerly Southport and Ormskirk)	71.0%	71.3%	69.6%
Barnsley Hospital NHS Foundation Trust	67.3%	63.2%	66.5%
North Middlesex University Hospital NHS Trust	70.1%	67.6%	64.4%
Oxford University Hospitals NHS Foundation Trust	68.5%	69.1%	63.7%
Northampton General Hospital NHS Trust	66.1%	65.0%	63.1%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	67.8%	63.5%	61.6%
Mid Cheshire Hospitals NHS Foundation Trust	64.8%	62.2%	60.7%
The Princess Alexandra Hospital NHS Trust	55.5%	53.8%	53.5%

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) ★		99.6	99.6		109.3	✗	▼		
1.2	Mortality - (SHMI)		100.0	100.0		103.5	✗	▲		
1.3	Never Events		0	0	0	0	✓	▬	✓	
1.4	Clostridium Difficile		13	<7	18	3	✗	▼	✗	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▬	✓	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.10	0.21	✗	▼	✓	
1.7b	Midwife to birth ratio (Actual for Month)		28			32	✗	▬		
1.8	Incident Rate (per 1,000 bed days)		50	50	55.93	63.91	✓	▲	✓	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		27	<14	11	2	✓	▬	✓	
1.11	MSSA		17	<9	6	2	✗	▼	✓	
1.12	VTE Assessment		95%	95%	97.7%	97.2%	✓	▼	✓	
1.14	Klebsiella Spp bacteraemia		14	7	3	1	✓	▼	✓	
1.15	P.aeruginosa bacteraemia		9	<5	3	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%	71.5%	39.8%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1%	1%	0.95%	1.68%	✗	▼	✓	
2.5	Over 75s Ward Moves at Night		1,500	750	775	111	✓	▲	✗	

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%	89.4%	88.2%	✓	▼	✓	
3.2	Ward Discharges by Midday		25%	25%	14.7%	18.4%	✗	▲	✗	
3.3	Weekend Discharges		63%	63%	59.1%	60.6%	✗	▲	✗	
3.5	Patients not meeting Criteria to Reside		50			72	✗	▲		
3.6a	Number of Stranded Patients (LOS>=7 Days)		184			247	✗	▲		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)		50			110	✗	▲		
3.8	Discharges from PDU (%)		12.5%	12.5%	8.9%	11.8%	✗	▲	✗	
3.9a	Ambulance Handovers <30 mins (%)		95%	95%	78.8%	77.1%	✗	▬	✗	
3.9b	Ambulance Handovers <60 mins (%)		100%	100%	96.4%	95.7%	✗	▼	✗	

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%	73.7%	70.0%	✗	▼	✗	
4.1b	Total time in ED no more than 12 hours		95%	95%	93.3%	92.9%	✗	▬	✗	
4.1c	Triage within 15 Minutes		90%	90%	64.1%	65.0%	✗	▼	✗	
4.2	RTT Incomplete Pathways <18 weeks		47.4%	43.7%		38.1%	✗	▼		
4.4	RTT Total Open Pathways		39,636	41,981		38,870	✓	▼		
4.5a	RTT Patients waiting over 52 weeks		1,920	2,240		3,963	✗	▼		
4.5b	RTT Patients waiting over 65 weeks		0	344		954	✗	▼		
4.6	Diagnostic Waits <6 weeks		85.6%	85.2%		62.3%	✗	▼		
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		99,428	14,281	Not Available	▼	Not Available	
5.1b	Total ASIs		0	0		2,112	✗	▲		
5.1c	Total RTT Non-Admitted Open Pathways		32,776	34,946		32,811	✓	▼		
5.1d	Total RTT Admitted Open Pathways		6,860	7,035		6,059	✓	▼		
5.2	A&E Attendances		103,507	51,110	49,685	8,396	✗	▼	✓	
5.3	Elective Spells		25,968	12,621	12,753	2,341	✓	▲	✓	
5.4	Non-Elective Spells		28,660	15,083	14,311	2,579	✗	▼	✓	
5.5	OP Attendances / Procs (Total)		409,197	202,514	213,829	34,639	✓	▼	✓	
5.6	Outpatient DNA Rate		6%	6%	5.8%	5.7%	✓	▬	✓	
5.7	Virtual Outpatient Activity		25%	25%	14.7%	13.5%	✗	▼	✗	

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	176,150	190,297	37,591	✓	▲	✓	
7.2	Pay £'000		(215,539)	(107,938)	(121,000)	(19,889)	✗	▲	✗	
7.3	Non-pay £'000		(100,693)	(49,875)	(56,369)	(9,219)	✗	▲	✗	
7.4	Non-operating costs £'000		(44,713)	(17,677)	(16,984)	(7,610)	✓	▼	✓	
7.5	I&E Total £'000		0	660	(4,056)	873	✓	▼	✗	
7.6	Cash Balance £'000			24,287		15,108	✗	▲		
7.7	Savings Delivered £'000		17,335	8,667	7,278	2,037	✓	▼	✗	
7.8	Capital Expenditure £'000		(46,842)	(21,632)	(20,175)	(4,689)	✗	▼	✗	
7.9	Elective Spells (% of 2019/20 performance)		102%	102%	103.8%	109.3%	✓	▲	✓	
7.10	OP Attendances (% of 2019/20 performance)		112%	112%	108.7%	105.1%	✗	▼	✗	

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%		5.1%	✓	▲		
8.2	Agency Expenditure %		5.0%	5.0%	4.1%	2.5%	✓	▲	✓	
8.3	Staff Sickness % - Days Lost (Rolling 12 months)		5.0%	5.0%		4.5%	✓	▬		
8.4a	Appraisals (excluding doctors)		90%	90%		90.0%	✓	▼		
8.5	Statutory Mandatory training		90%	90%		95.0%	✓	▬		
8.6	Substantive Staff Turnover		12.5%	12.5%		14.1%	✗	▬		

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		32	✗	▬		
O.2	Rebooked cancelled OPs - 28 day rule		90%	90%	83.1%	96.4%	✓	▲	✗	
O.4	Overdue Incidents >1 month		TBC	TBC		455	Not Available	▼		
O.5	Serious Incidents		75	<38	17	4	✓	▼	✓	

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.

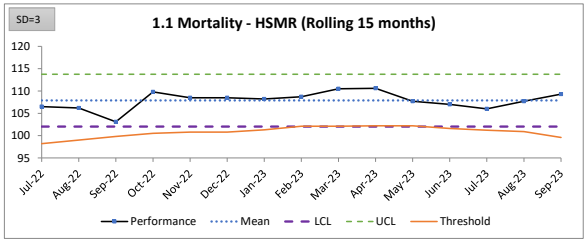
YTD Position

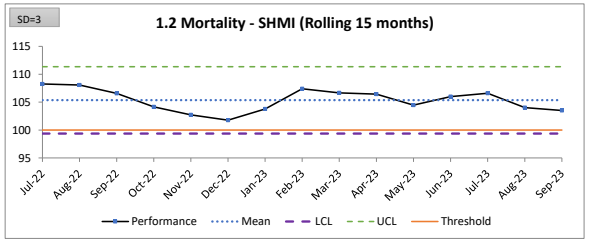
✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
✗	Annual Target breached

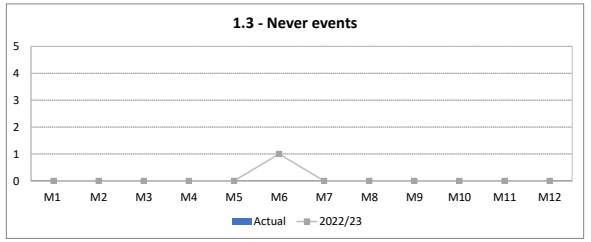
Data Quality Assurance Definitions

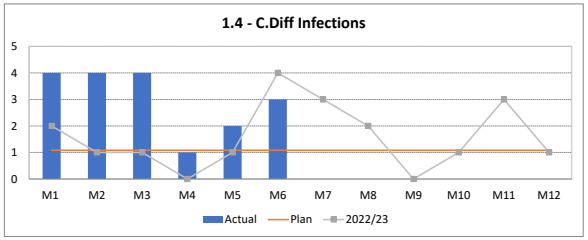
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory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

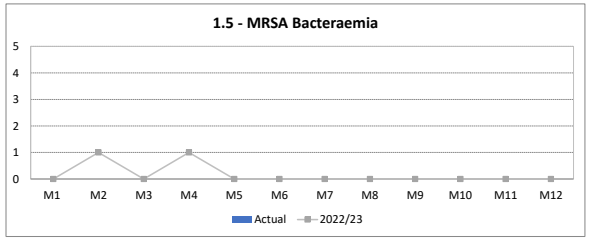
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

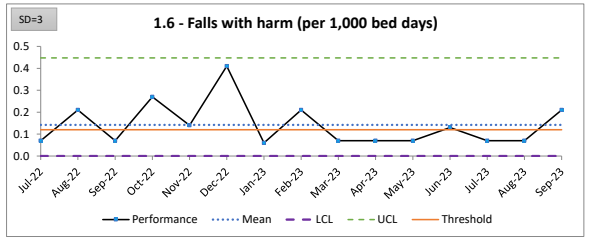


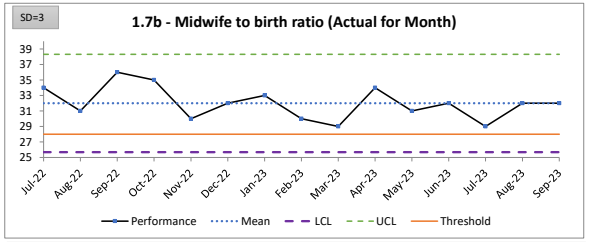


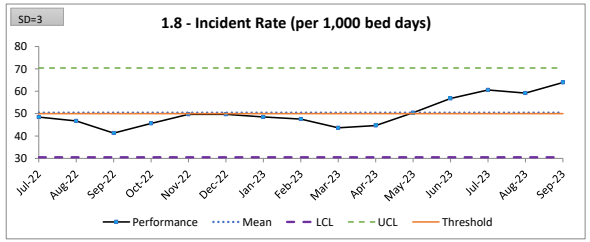


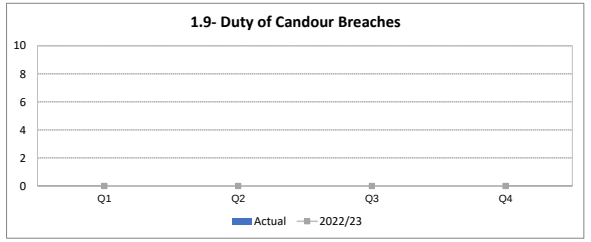


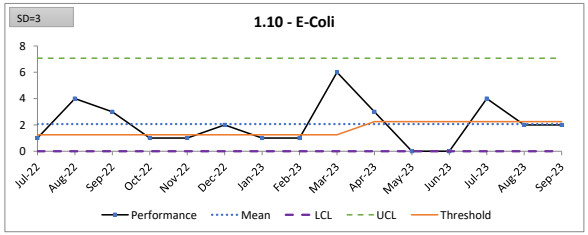


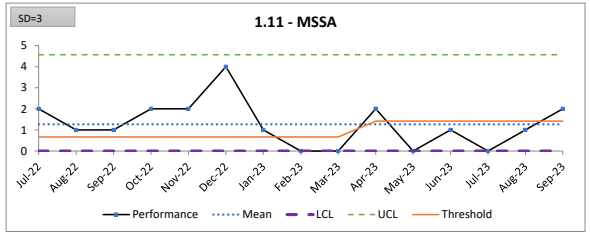


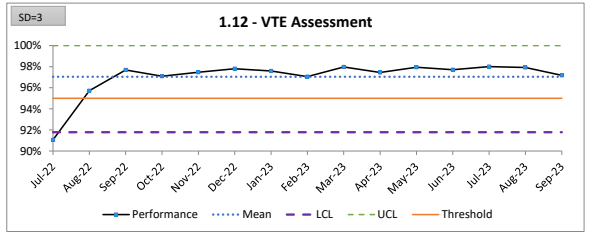


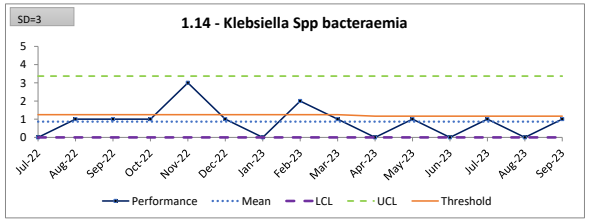


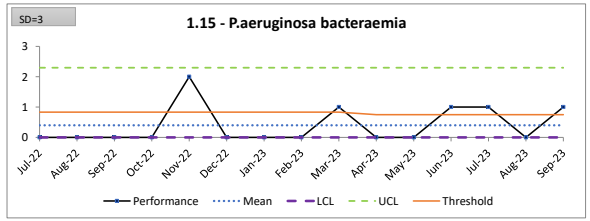








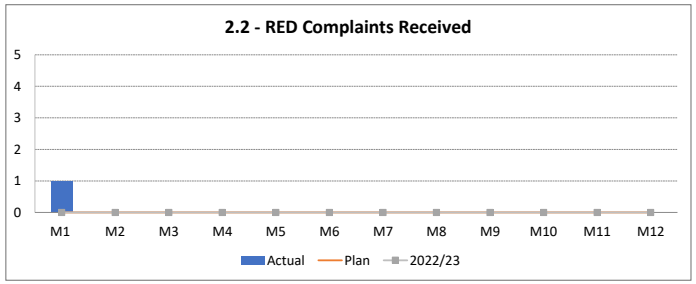


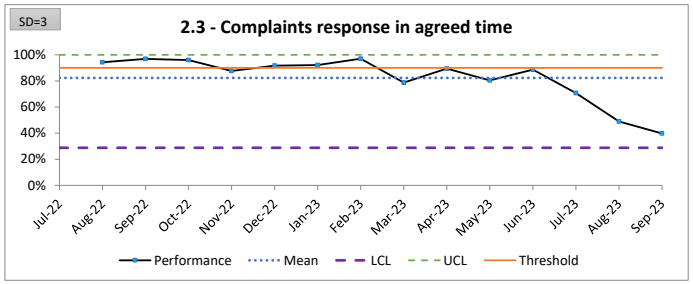


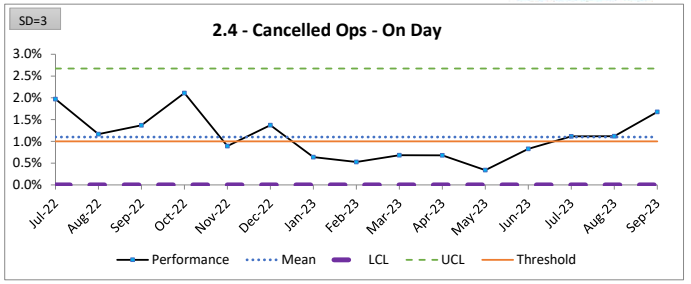
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

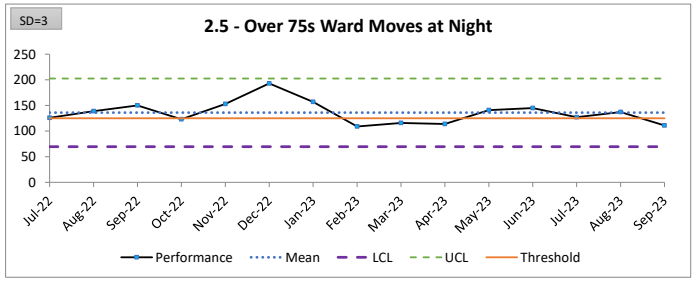
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

OBJECTIVE 2 - PATIENT EXPERIENCE





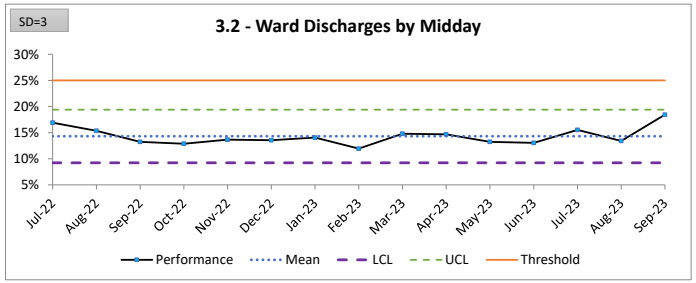


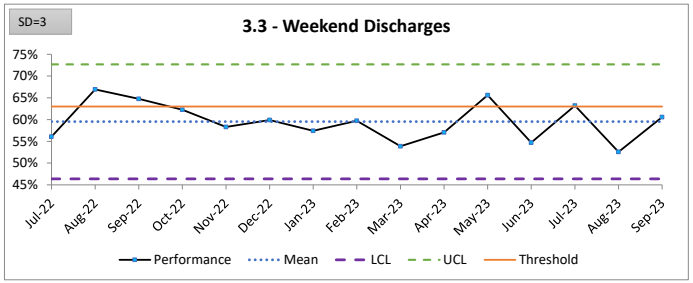


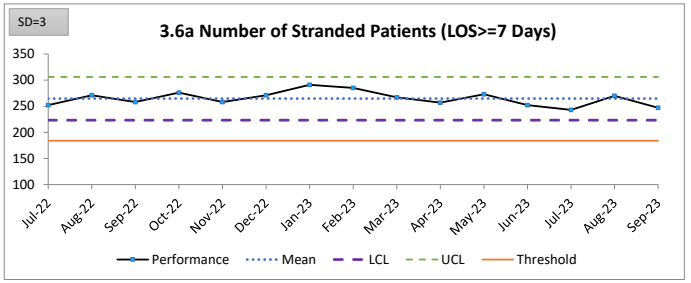
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

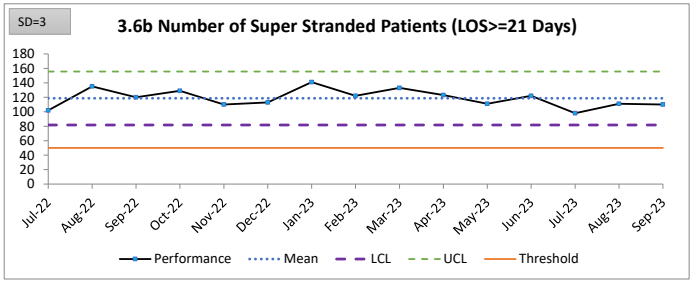
- Performance activity on a rolling 15 months/quarterly
- Average on a rolling 15 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

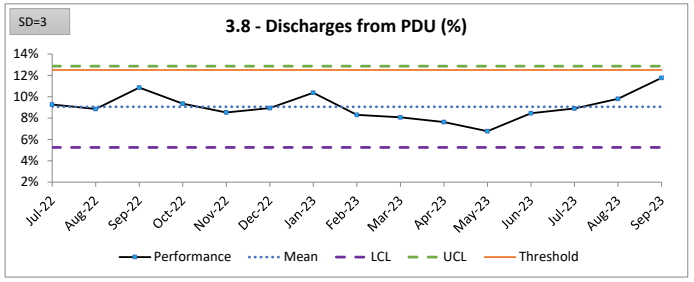
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

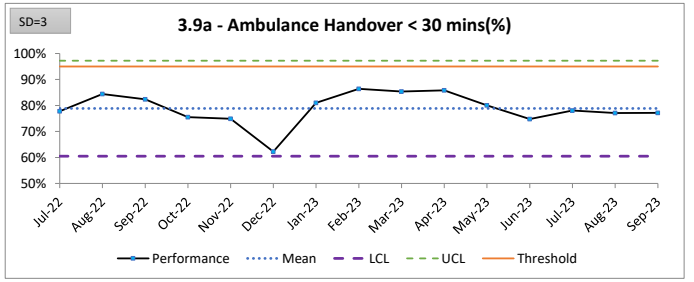


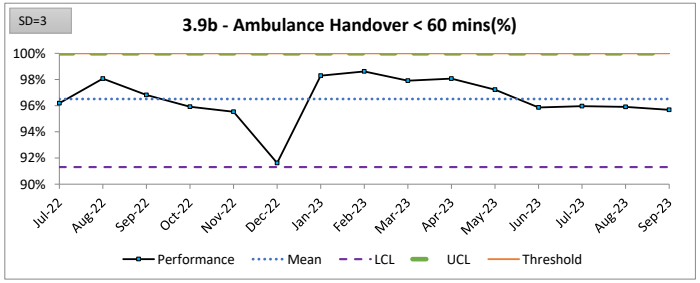












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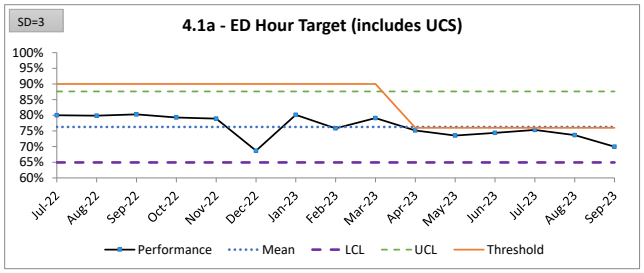
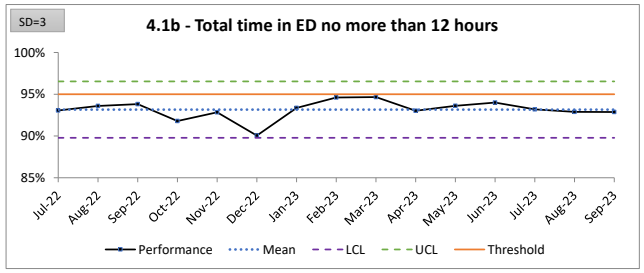
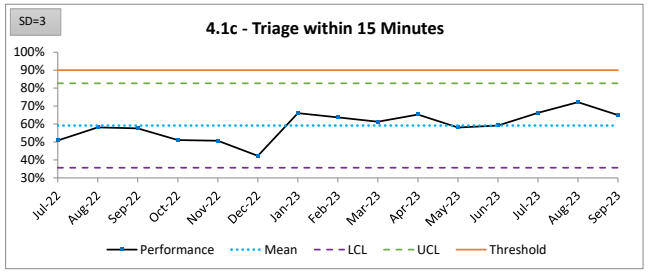
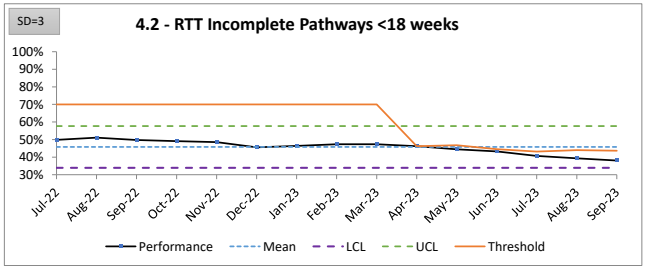
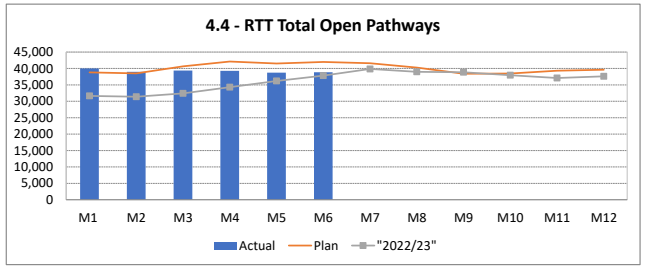
OBJECTIVE 4 - KEY TARGETS

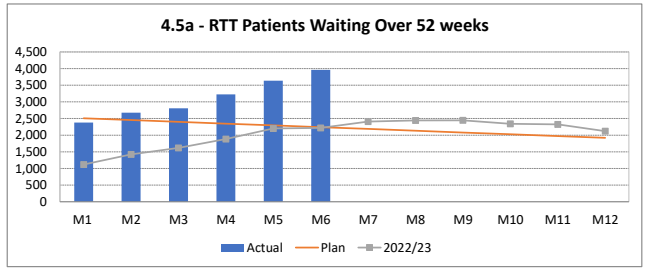


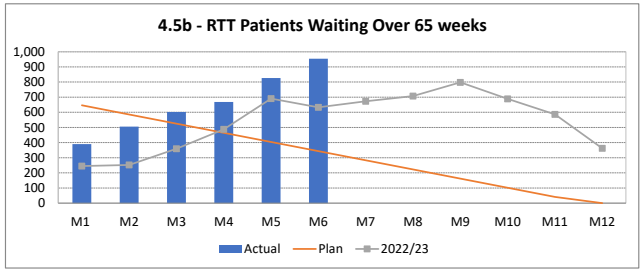


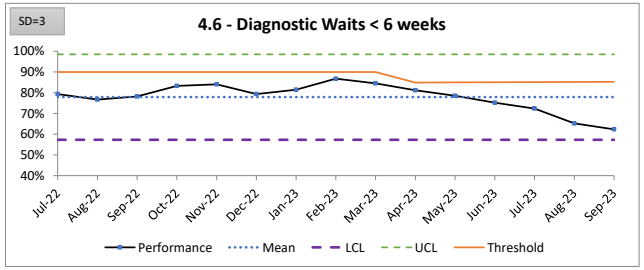


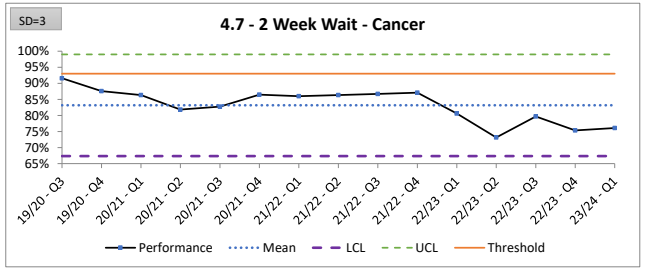


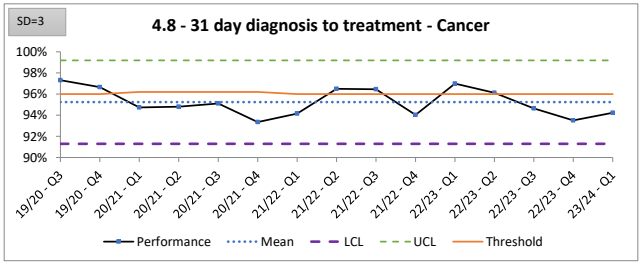


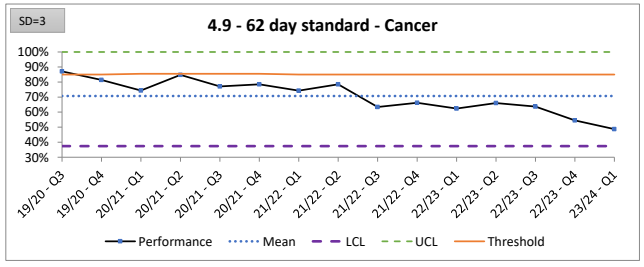












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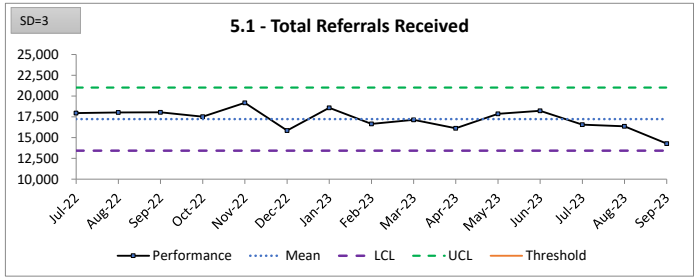
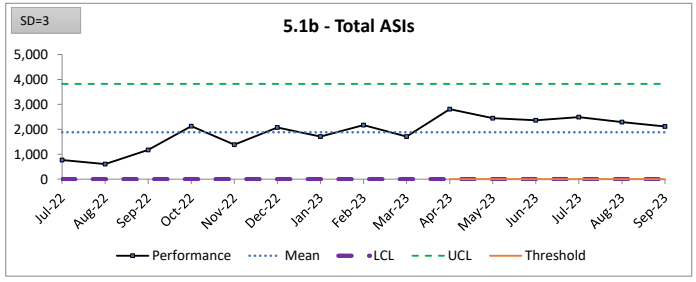
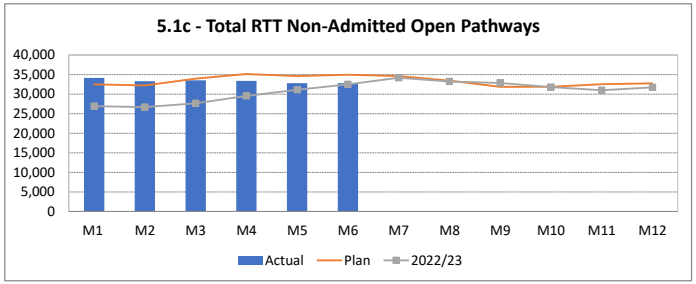
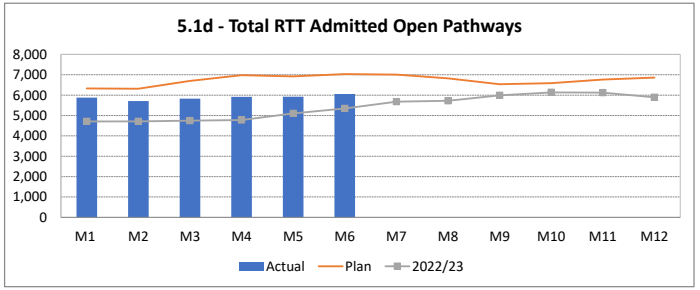
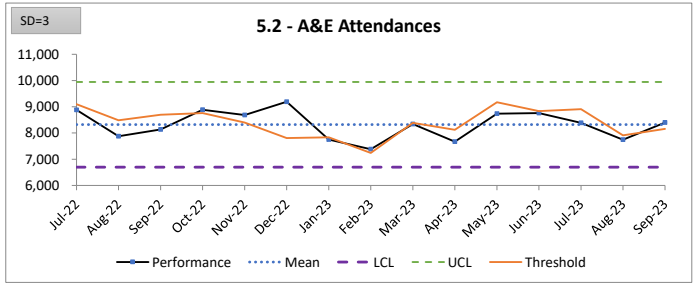
OBJECTIVE 5 - SUSTAINABILITY

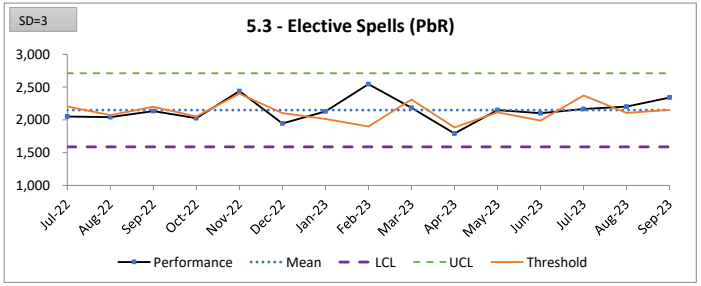


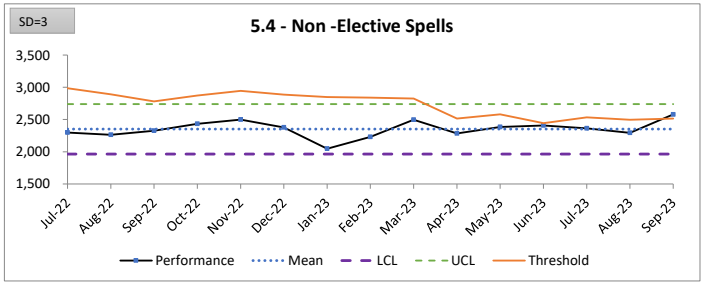


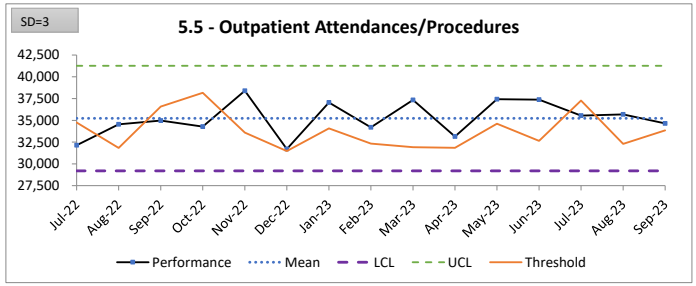


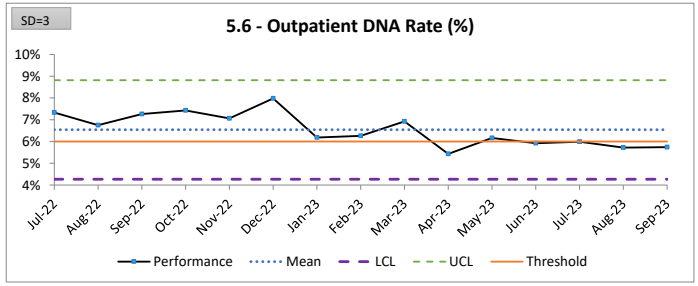












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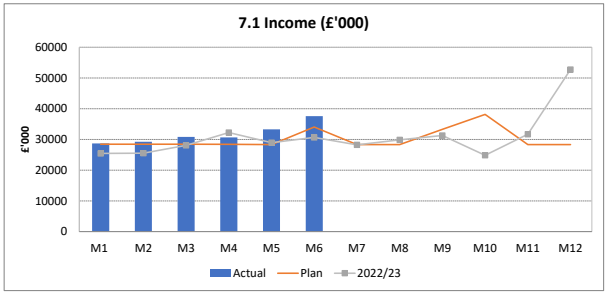
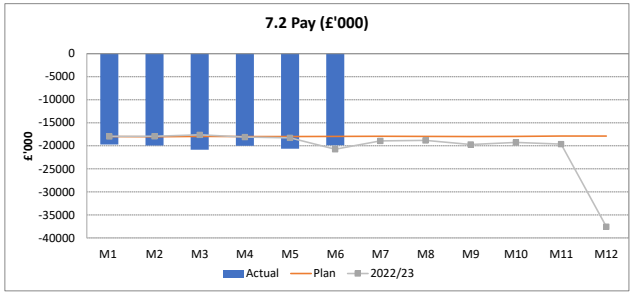
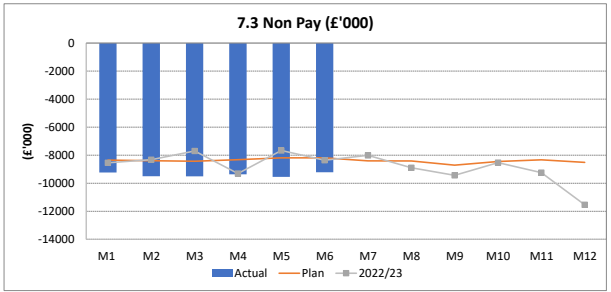
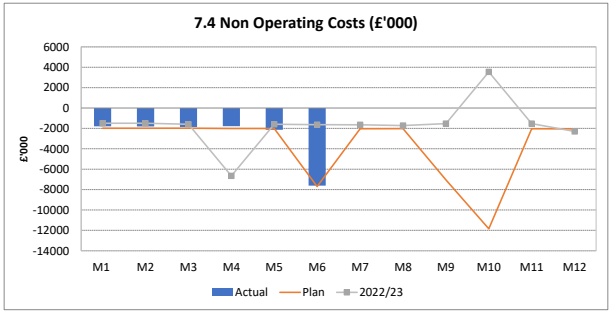
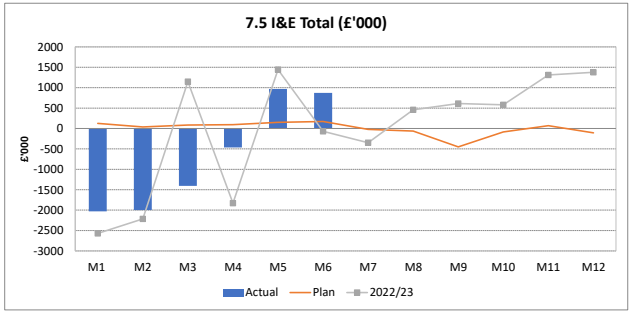
OBJECTIVE 7 - FINANCIAL PERFORMANCE

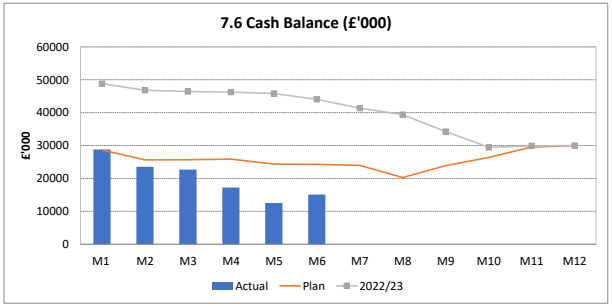


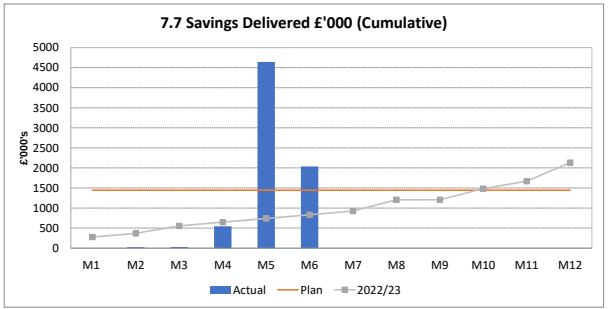


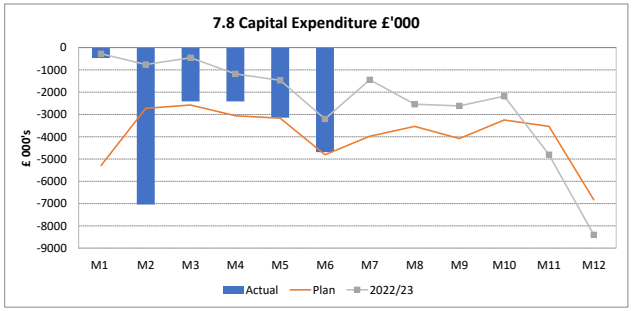


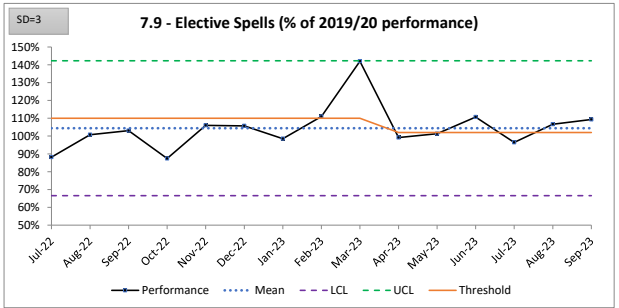


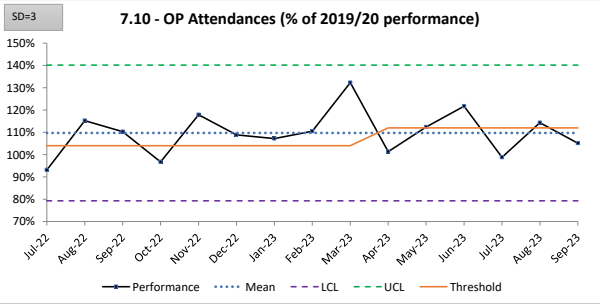












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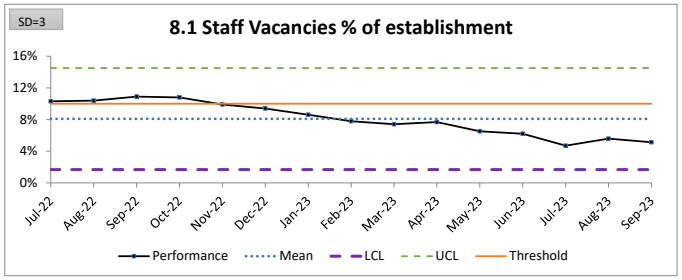
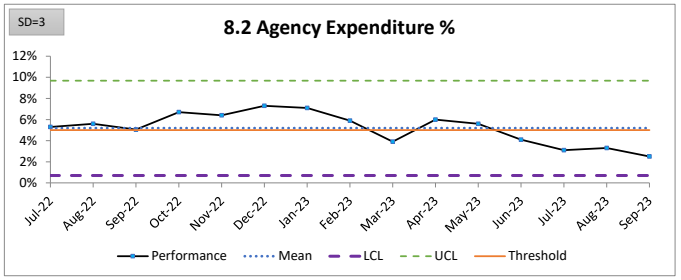
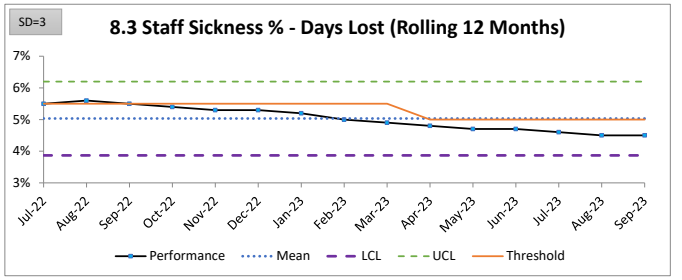
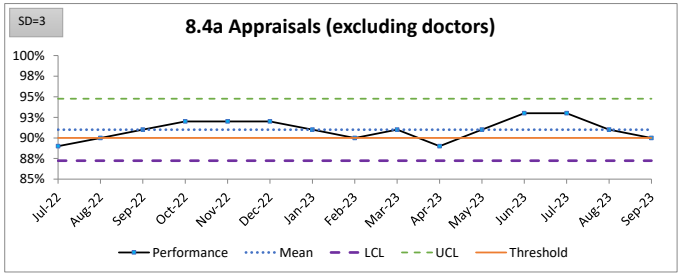
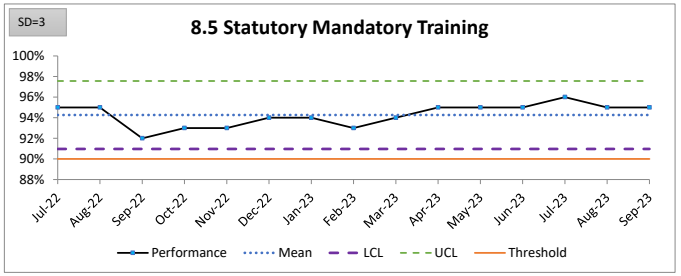
OBJECTIVE 8 - WORKFORCE PERFORMANCE

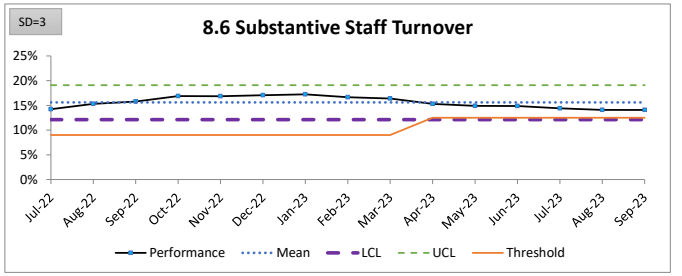












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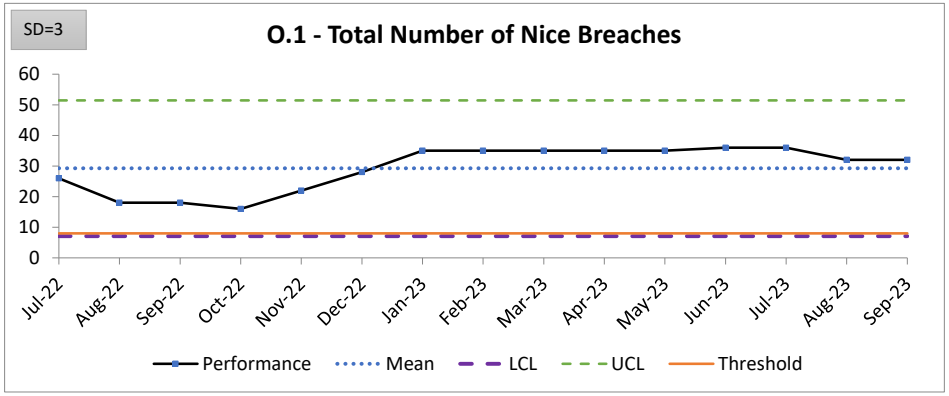

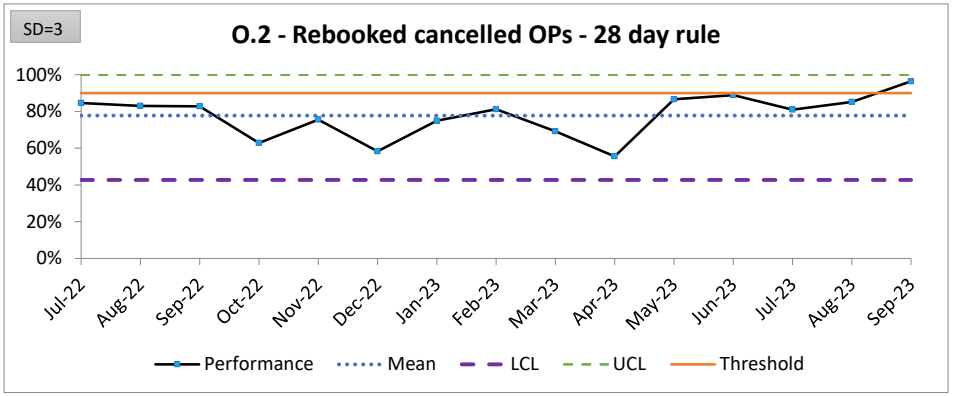

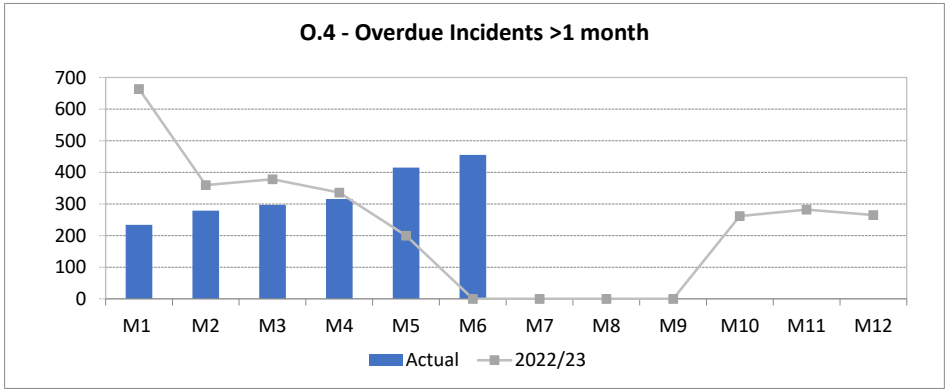

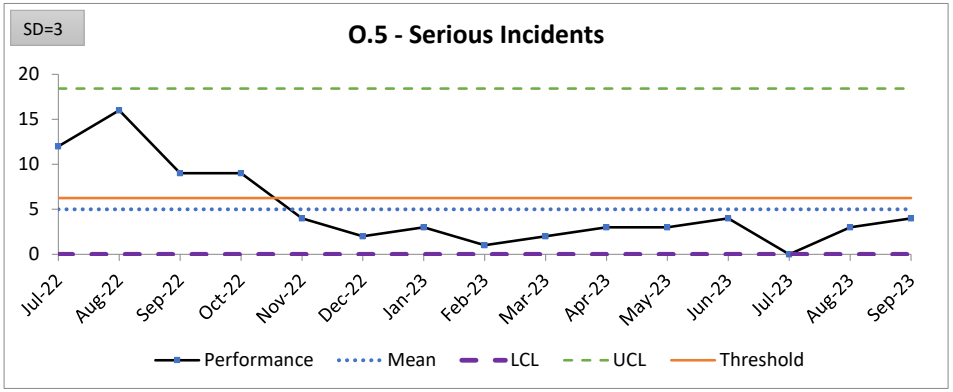

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Confidential
- For Internal Circulation Only

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Public Board**	**Date: 2nd November 2023**
Report Title	**Finance Paper Month 6 2023-24**	**Agenda Item Number: 16**
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 6 (September 2023).		
Key Messages to Note	The Trust is reporting a £4.1m deficit (on a Control Total basis) to the end of the September 2023 which is £4.7m adverse to plan. The monthly result for September was a surplus of £0.9m. This improvement has been driven by a recognition of £3.2m of elective recovery fund (ERF) over-performance as per NHS England (NHSE) guidance. 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 cost pressures take effect. Sustained closure of escalation capacity will be challenging during the winter period. The savings target for the year is £17m (4.8% of expenditure), £7.3m was reported to September representing a significant improvement on last month's total of 5.2m. There has been continued progress with identifying efficiencies against the annual target which is noted in the report.		
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 30th SEPTEMBER 2023

TRUST BOARD

CONTENTS

1	Executive Summary	Page 3
2	Financial Performance	Page 4
3	Clinical Income	Page 5
4	Efficiency Savings	Page 6
5	Capital	Pages 7
6	Cash	Page 8
9	Statement of Financial Position (Balance Sheet)	Pages 9
12	Recommendations to the Board	Page 10
13	Appendices	Pages 11-13
14	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 due to high-cost drugs (HCD) over performance, Elective Recovery Fund over-performance, and additional 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 combined cost of temporary staff in escalation wards (£1.9m), supernumerary costs of international recruits (£1m) and industrial action costs (£0.7m). Agency expenditure has reduced by c.60% since April, although bank expenditure remains static. Non-pay is above plan due to higher drugs costs (£2.2m), clinical consumables in unfunded escalation areas (£2m) and clinical outsourcing (£1.8m).

(7.) Control Total Deficit - The Trust is reporting a £4m deficit to the end of September.

(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 – £7.3m efficiency delivered to date (£3.9m budget removed + £3.4m pipeline). Forecast of £17m made-up of risk adjusted pipeline and non-recurrent mitigation.

(11.) Cash – Cash balance is £15.1m, equivalent to 15 days cash to cover operating expenses. No payment received for ERF M1-6 (from NHSE), and grant drawdown (£5.7m) from local authority in-progress for Radiotherapy Centre development.

(12.) Capital – Capital expenditure is lower than plan, due to timing of business case approvals. There is no risk to slippage in expenditure plans at year end. The Trust has recognised £5.7m of donated income in month relating to the Radiotherapy project from MK Council.

Ref	All Figures in £'000	Month 6 YTD Plan	Month 6 YTD Actual	Month 6 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	**Clinical Revenue**	162,749	170,679	7,930	325,498	325,498	-	
2	**Other Revenue**	16,760	19,618	2,857	42,168	42,168	-	
3	**Pay**	(111,556)	(121,000)	(9,444)	(222,774)	(222,774)	-	
4	**Non Pay**	(49,954)	(56,369)	(6,414)	(100,853)	(100,853)	-	
5	**Financing & Non-Ops**	(11,947)	(11,430)	517	(24,139)	(24,139)	-	
6	**Surplus/(Deficit)**	6,052	1,498	(4,553)	19,900	19,900	-	
7	**Control Total Surplus/(Deficit)**	658	(4,055)	(4,712)	-	-	-	
	Memos							
8	**IA Cost**	-	2,426	2,426	-	4,852	4,852	
9	**High Cost Drugs**	(11,534)	(12,402)	(868)	(23,048)	(23,048)	-	
10	**Financial Efficiency**	8,668	7,278	(1,390)	17,335	17,335	-	
11	**Cash**	24,287	15,133	(9,154)	29,995	29,995	-	
12	**Capital Plan**	(15,932)	(14,318)	1,614	(46,842)	(51,531)	(4,689)	

Key message
The Trust is reporting a £4.1m deficit (on a Control Total basis) to the end of the Sep 2023. This is £4.7m adverse to plan. The Trust is forecasting a breakeven year-end position, this would be heavily reliant on non-recurrent mitigation and/or receipt of additional funding from NHSE for the impact of industrial action and winter related cost pressures.
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.
There has been good progress with mitigating the shortfall to annual efficiency target, however this is supported by non-recurrent schemes of material value.
ERF performance is currently above the new 104% target, with income showing £3.1m above the target as at M06. The Trust has not yet received payment for this activity.
The capital expenditure programme is £1.6m below plan, no risk has been identified to scheme expenditure at year-end. The Trust is awaiting approval for the £5m shortfall in the approved 23/24 ICS CDEL allocation.

FINANCIAL PERFORMANCE

2. **Summary Month 6**

Financial performance on a Control Total basis is a deficit of £4.1m YTD and a surplus of £0.9m in month, against a break-even plan. Overspends on pay costs are partly offset by increased income year to date.

3. Clinical Income

Clinical income shows a favourable variance of £7.9m YTD and £1.3 in-month. This is due to the income recognised for UEC, ERF and HCD over-performance, along with deferred income to support the current cost pressures. Further detail is included in Appendix 1.

4. Other Income

Other income shows a favourable variance of £2.7m YTD and £0.7m in month. Most 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 £9.4m YTD and £0.3m in month due partly to the cost of escalation/IA/delays in CIP delivery. Spend on temporary staffing costs has reduced since last month. Further detail is included in Appendices 1 & 4.

6. Non-Pay

Non-pay is above plan by £1m in month and £6.4m YTD due to increased spend on drugs and clinical consumables relating to both escalation areas and inflationary pressures. Further detail is included in Appendices 1 & 5.

7. Non-Operating Expenditure

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

All Figures in £'000	Month 6 Plan	Month 6 Actual	Month 6 Var	Month 6 YTD Plan	Month 6 YTD Actual	Month 6 YTD Var	Plan	Plan Forecast	Plan Var
Clinical Revenue	28,072	29,366	1,294	162,749	170,679	7,930	325,498	325,498	0
Other Revenue	1,776	2,523	747	11,060	13,759	2,698	21,646	21,646	0
Total Income	29,848	31,889	2,041	173,809	184,438	10,629	347,144	347,144	0
Pay	(19,524)	(19,889)	(365)	(111,556)	(121,000)	(9,444)	(222,774)	(222,774)	0
Non Pay	(8,202)	(9,219)	(1,017)	(49,954)	(56,369)	(6,414)	(100,853)	(100,853)	0
Total Operational Expenditure	(27,725)	(29,108)	(1,383)	(161,510)	(177,369)	(15,858)	(323,627)	(323,627)	0
EBITDA	2,123	2,781	658	12,299	7,069	(5,230)	23,517	23,517	0
Financing & Non-Op. Costs	(1,951)	(1,908)	43	(11,641)	(11,124)	517	(23,517)	(23,517)	0
Control Total Deficit (excl. top ups)	**172**	**873**	**701**	**658**	**(4,055)**	**(4,712)**	**0**	**0**	**0**
Control Total Deficit (incl. top ups)	**172**	**873**	**701**	**658**	**(4,055)**	**(4,712)**	**0**	**0**	**0**
Donated income	5,700	5,702	2	5,700	5,859	159	20,522	20,522	0
Depreciation	(51)	(51)	0	(306)	(305)	1	(622)	(622)	0
Impairments & Rounding	0	0	0	0	(1)	(1)	0	0	0
Reported deficit/surplus	**5,821**	**6,524**	**703**	**6,052**	**1,498**	**(4,553)**	**19,900**	**19,900**	**0**

Key message

The financial position on a Control Total basis is a deficit of £4m YTD and a surplus of £0.7m in month, the in-month position is better than plan. The YTD 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 6.

Deferred income of £1m has been released to support the current position, this is £0.5m higher than the budget year to date.

CLINICAL INCOME

8. Block contracts

The Trust block contracts (c£242m) makes up around 74% of the total clinical income, covering all activity except for planned care (covered by ERF), diagnostic tests, HCD and devices, specialised chemotherapy activity, and the Community Diagnostic Centre (CDC).

9. Elective Recovery Fund

Planned care income is managed through the ERF scheme. The target for MKUH originally assigned was 109% above 2019/20 activity level which was revised to 106% following appeal. This has subsequently been reduced by a further 2% to **104%.** This final adjustment was made to recognise the impact of the April industrial action. Further adjustments are expected for the subsequent industrial action(s), but these have not been announced by NHSE yet.

The Trusts M6 ERF actual position shows an expected **£2.1m** over performance compared to the target. Combined with the Advice and Guidance (A&G) diverts of £1m, **£3.1m** has been reported as the YTD ERF benefit.

The Trust has developed a reporting model to estimate and track our performance against ERF targets using our internal data and nationally reported guidance on the ERF rules.

Activity and the ERF payment due was estimated internally in September for months 1-6 using:

1. April (M1) to June (M4) fully coded activity ("freeze data");
2. August (M5) partially coded activity ("flex data"); and
3. September (M6) indicative activity which has a high volume of uncoded activity.

This showed estimated overall activity of 114% versus 2019/20, and a potential ERF additional payment due of £2.1m for the first six months (average of £0.35m per month).

NHSE recently published the Q1 data for MKUH, an activity level of 115% versus 2019/20 and a payment due of **£1.7m** (average payment of £0.57m per month). The NHSE numbers are higher due to a difference in plan phasing, and because they are reporting the freeze data months, whilst the Trust have included the flex and indicative partially coded month in the estimate values. The underlying data issues appear to have been corrected in the NHSE Q1 data.
Whilst the overall achievement is close to our internal predictions there is further work to be done to have full confidence in predicting the full year effect. The Trust has also not yet received any payment for ERF activity during the year.

The **day case** and **outpatient attendances** are tracking above plan, whilst **elective inpatient** care and **outpatient procedures** are below. The estimated position includes an accrual for the high volume of uncoded inpatient activity and uncoded procedures appearing as attendances.

Key message
Overall, ERF for the first months of the year is tracking above plan and this is endorsed by nationally reported performance. £3.1m of additional income has been included in the financial position, based on a mix of reported performance, internal estimates and ICB A&G information.

Follow up attendances, accident & emergency (A&E), unplanned admissions, critical care, and maternity activity is part of the fixed block, so the cost of additional activity is unfunded. Currently unplanned admissions are below plan, whilst High-Cost Drugs and Devices, Maternity, Critical Care, and Pathology are over performing.

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 table below reflects the latest forecast position. £7.3m was reported externally (via the national PFR system) which represents schemes recognised to date plus schemes expected to deliver in year and additional ERF to M6 of £3.1m.

	Current Status								
			Pipeline						Non
Division	Target	Tracker Value	Green	Amber	Red	Total	Variance	Recurrent	Recurrent
Medicine	3,450	1,979		21	23	2,023	*(1,427)*	*2,003*	*20*
Surgery	2,600	875	882	300	332	2,389	*(211)*	*504*	*1,885*
Womens and Childrens	1,400	1,690	-	-	-	1,690	*290*	*585*	*1,105*
Core Clinical	2,500	443	108	257	176	984	*(1,516)*	*753*	*231*
Corporate	2,385	2,239	840	-	-	3,079	*694*	*831*	*2,248*
Trustwide	5,000	-	5,400			5,400	*400*		*5,400*
Total	**17,335**	**7,226**	**7,230**	**578**	**531**	**15,565**	***(1,770)***	***4,676***	***10,889***

11. The risk-adjusted savings presented to date totals £16.4m (FYE). Savings attributed to enhanced controls in temporary staffing and escalation beds are now included in these figures.

    Initial progress has been observed in agency expenditure controls. Control processes are also in-track for WLI usage, outsourcing spend and escalation bed cost.

    All pipeline schemes should be progressed to CIP QIA for review by the Quality Group.

    Assessment of the ERF income opportunity in the light of the revised ERF target of 104% has been estimated at £3.1m YTD and £6.2m FYE.

    See appendix 14 for the detailed schemes that are currently being tracked.

Key message

The Trust has an efficiency requirement of £17.3m for the 2023/24 financial year. There is a small shortfall against the year-to-date savings target at Month 6. Progress has been made during September with a risk adjusted position of £16.4m (including ERF). 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 September is £14.3m which is £1.6m below YTD plan. This position has recognised £5.7m of donated funding relating to the radiotherapy centre 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 £10.4m, an additional 4.7m in year. This includes fees for 3 enabling projects associated with the NHP, Imaging Centre, a multi-storey car park and additional HV generator capacity as well UEC and Digital Diagnostic funding. The Trust is awaiting approval for its IFRS16 lease funding of £2.4m .The current requested CDEL is £31.0m 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 £51.5m 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.

	ICS Required Funding 2023/24	ICS Approved CDEL Allocation 2023/24 including bonus	National Approved CDEL Allocation 2023/24	*Awaiting Approval CDEL 2023/24*	***Total CDEL inc awaiting approval***	Externally Funded	Total Capital
Funding Subcategory	**Internally Funded**	Internally Funded	Nationally funded			**Externally Funded**	
		£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			1.90		*1.90*		
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	10.38	7.36	**31.01**		**31.01**
Donated Funding							
Council (Radiotherapy & CDC)						10.00	
Donor (Radiotherapy)						5.70	
Salix						4.82	
Total Donated Funding						**20.52**	**20.52**
Total Capital							**51.53**

Capital Item	**Value of approved BC £m** £m	**23/24 YTD Mth 6 Plan £m**	**23/24 YTD Mth 6 Actual £m**	**YTD Variance to YTD Plan £m** £m	**Status**
Pre-commitments from 22/23	**1.89**	**0.88**	**0.71**	**- 0.17**	
Scheme Allocations For 23/24 schemes (detailed below)	**8.74**	**6.23**	**7.36**	**1.13**	
CBIG including IT and Contingency	4.01	1.17	0.77	-0.40	
Strategic Radiotherapy	1.91	1.03		- 1.03	
Strategic Salix	1.99	1.53	0.40	- 1.13	
Strategic Contingency Allocated	0.03		0.02	0.02	
Hospital capacity (Build & Fees)	0.80	0.00	0.00	0.00	
Funding to be allocated	0.00	2.50	0.00	-2.50	
Adjustment			6.16	6.16	
(ICS CDEL Requested)	**10.63**	**7.11**	**8.07**	**0.96**	
Nationally approved schemes (detailed below)	**8.68**	**3.97**	**3.21**	**- 0.75**	
NHP	1.16	0.58	0.43	- 0.14	
Digital Diagnostic Funding -Pathology	0.36	0.00	0.05	0.05	
Digital Diagnostic Funding - Imaging	0.00	0.00	0.00	-	
CDC - Lloyds Court & Whitehouse Park	3.95	3.39	2.74	- 0.65	
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	**19.31**	**11.07**	**11.28**	**0.21**	
New Leases Impact under IFRS 16 - held centrally	2.36	2.32	2.32	0.00	
Submitted CDEL capital plan	**21.67**	**13.39**	**13.60**	**0.21**	
Donated Funded Schemes (excluded from CDEL)	20.55	2.54	0.69	- 1.85	-
Total Capital spend	**42.22**	**15.93**	**14.30**	**-1.64**	

CASH

16. Summary of Cash Flow

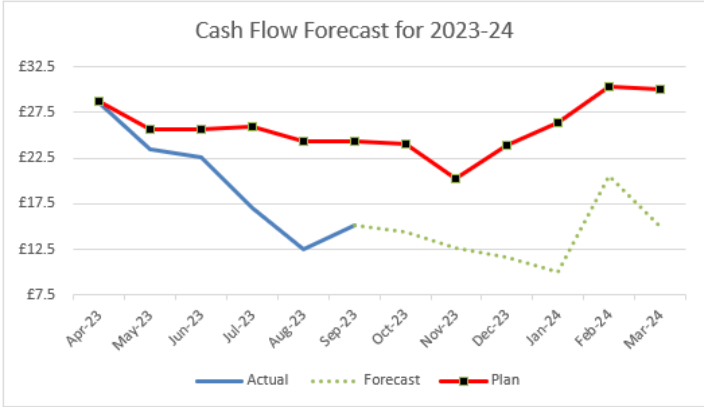
The cash balance at the end of September was £15.1m, £8.9m lower than the planned figure of £24m and a £2.6m increase on last month's figure of £12.5m (see opposite).
See Appendices 6-8 for the cashflow detail.

17. Cash arrangements 2023/24

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

18. Better Payment Practice

The Trust has fallen below the national target of 95% of all bills paid within the target timeframe in terms of value and volume. This is due 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 M6 YTD Number	Actual M6 YTD £'000	Actual M5 YTD Number	Actual M5 YTD £'000
Non NHS				
Total bills paid in the year	35,955	101,523	30,058	85,665
Total bills paid within target	32,699	93,763	27,132	79,421
Percentage of bills paid within target	**90.9%**	**92.4%**	**90.3%**	**92.7%**
NHS				
Total bills paid in the year	1,056	5,147	796	3,767
Total bills paid within target	820	2,490	627	1,467
Percentage of bills paid within target	**77.7%**	**48.4%**	**78.8%**	**38.9%**
Total				
Total bills paid in the year	**37,011**	**106,670**	**30,854**	**89,431**
Total bills paid within target	**33,519**	**96,253**	**27,759**	**80,887**
Percentage of bills paid within target	**90.6%**	**90.2%**	**90.0%**	**90.4%**

Key message
Cash at the end of September was behind plan at £15.1m. 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 9. The key movements include:

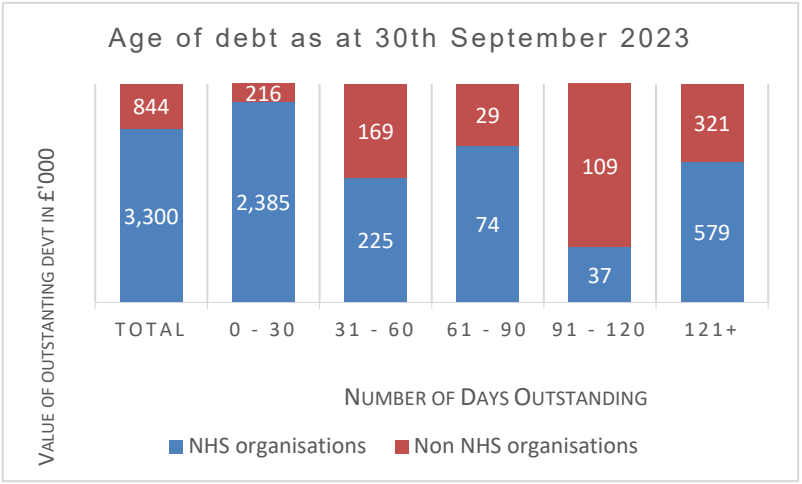
- Non-Current Assets have increased from March 23 by £11.7m; this is driven by capital purchases in year offset by in year depreciation.
- Current assets have decreased by £9.3m; this is due to the decrease in cash £14.9m, offset by a £5.6m increase in receivables.
- Current liabilities have decreased by £4.7m; this is due to the £5.5m decrease in payables, offset by the £2.1m increase in Deferred Income.
- Non-Current Liabilities have increased from March 23 by £2.7m; this is due to the Right of Use assets, related to IFRS 16.

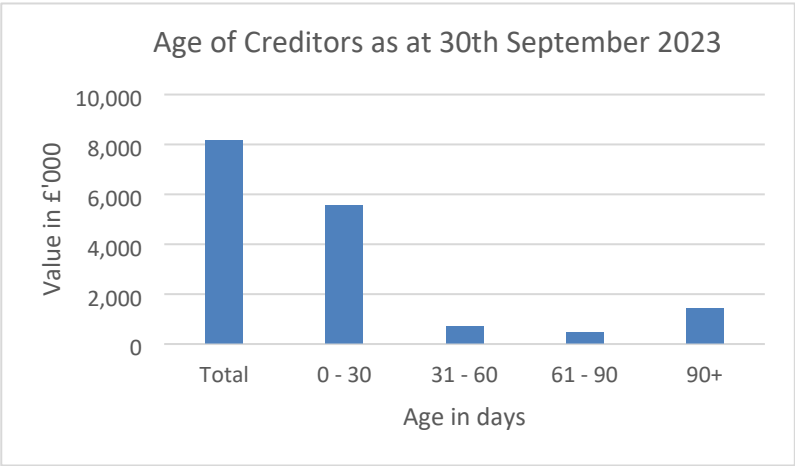
20. Aged debt

- The debtors position as of September 23 is £4.1m, which is an increase of £1.5m from the prior month. Of this total £0.9m is over 121 days old; the detail is shown in Appendix 10.
- The three largest NHS debtors are, Bedfordshire Hospitals NHS FT £0.9m relating to Cancer Alliance Funding 23/24, CNWL £0.5m relating to M1-M5 Non-Health SLA recharge and NHS Buckinghamshire, Oxfordshire & Berkshire West ICB for 22/23 Over Performance recharge £0.5m. The largest non-NHS debtors include £2.4m for overseas patient, £0.2m with Medical Property Management for utility recharges and NHS Property Services re utility recharges £0.1m. Further details of the aged debtors are shown in Appendix 11.

21. Creditors

- The creditors position as of September 23 is £8.1m, which is an increase of £0.1m from the prior month. Of this, £2.6m is over 30 days with £2.0m approved for payment. The breakdown of creditors is shown in Appendix 12.





Key message

Main movements in year on the statement of financial position are the reduction in cash of £14.9m, the non-current assets increase of £11.7m, the current liabilities decrease of £4.7m and the non-current liabilities increase of £2.7m.

RECOMMENDATIONS TO BOARD

22. Finance & Investment Committee is asked to note the financial position of the Trust as of 30th September and the proposed actions and risks therein.

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 30th September 2023

	FY23	M6 CUMULATIVE			M6			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M5 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	50,893	24,921	26,907	1,986	4,245	6,383	2,138	4,325 ▲	2,058
Elective admissions	31,551	15,373	15,621	247	2,636	2,390	(246)	2,883 ▼	(493)
Emergency admissions	84,791	45,286	45,275	(11)	7,460	7,454	(7)	7,571 ▼	(118)
Emergency adm's marginal rate (MRET)	0	0	0	0	0	0	0	0 ▲	0
Readmissions Penalty	0	0	0	0	0	0	0	0 ▲	0
A&E	19,738	9,631	9,631	0	1,506	1,506	(0)	1,515 ▼	(8)
Other Admissions	2,168	1,073	1,072	(1)	193	193	(0)	169 ▲	24
Maternity	20,418	9,999	9,995	(3)	1,881	1,882	1	1,639 ▲	243
Critical Care & Neonatal	6,713	2,993	2,998	5	349	349	(0)	550 ▼	(201)
Excess bed days	0	0	0	0	0	0	0	0 ▲	0
Imaging	6,815	3,284	3,284	0	615	615	0	582 ▲	33
Direct access Pathology	5,792	2,764	2,764	0	493	493	(0)	486 ▲	7
Non Tariff Drugs and Devices (high cost/individual drugs)	21,142	10,342	10,347	5	1,839	1,839	(0)	1,809 ▲	31
Other (inc. home visits and best practice tariffs)	5,965	2,153	8,992	6,840	84	629	545	4,044 ▼	(3,415)
COQUINS	0	0	0	0	0	0	0	0 ▲	0
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0 ▲	0
RTT Plans	0	0	0	0	0	0	0	0 ▲	0
Other Adj	0	0	0	0	0	0	0	0 ▲	0
National Block/Top up	69,513	34,929	33,793	(1,136)	6,769	5,632	(1,136)	5,632 ▲	0
MKCCG Block adj	0	0	0	0	0	0	0	0 ▲	0
Prior Month Adj		0	0	0	0	0	0	0 ▲	0
Contract Income CIP		0	0	0	0	0	0	0 ▲	0
Delayed Discharges		0	0	0	0	0	0	0 ▲	0
Brokerage	0	0	0	0	0	0	0	0 ▲	0
Clinical Income	**325,497**	**162,749**	**170,679**	**7,930**	**28,072**	**29,366**	**1,294**	**31,205 ▼**	**(1,839)**
Non-Patient Income	21,646	11,060	13,759	2,698	1,776	2,523	747	1,925 ▲	598
Donations	20,522	5,700	5,859	159	5,700	5,702	2	157 ▲	5,545
Non-Patient Income	**42,168**	**16,760**	**19,618**	**2,857**	**7,476**	**8,225**	**749**	**2,082 ▲**	**6,143**
TOTAL INCOME	**367,665**	**179,509**	**190,297**	**10,788**	**35,548**	**37,591**	**2,043**	**33,287 ▲**	**4,304**
EXPENDITURE									
Pay - Substantive	(202,126)	(101,140)	(102,074)	(934)	(17,759)	(17,204)	555	(17,611) ▲	407
Pay - Bank	(11,281)	(5,508)	(9,714)	(4,206)	(924)	(1,522)	(598)	(1,573) ▲	51
Pay - Locum	(3,064)	(1,550)	(3,752)	(2,202)	(296)	(579)	(284)	(697) ▲	118
Pay - Agency	(5,591)	(2,993)	(4,960)	(1,966)	(487)	(504)	(17)	(674) ▲	170
Pay - Other	(821)	(410)	(500)	(90)	(68)	(79)	(11)	(77) ▼	(2)
Pay CIP	41	20	0	(20)	3	0	(3)	0 ▲	0
Vacancy Factor	69	26	0	(26)	7	0	(7)	0 ▲	0
Pay	**(222,774)**	**(111,556)**	**(121,000)**	**(9,444)**	**(19,524)**	**(19,889)**	**(365)**	**(20,631) ▲**	**742**
Non Pay	(77,805)	(38,421)	(43,967)	(5,546)	(6,295)	(7,266)	(971)	(7,314) ▲	48
Non Tariff Drugs (high cost/individual drugs)	(23,048)	(11,534)	(12,402)	(869)	(1,907)	(1,953)	(46)	(2,235) ▲	282
Non Pay	**(100,853)**	**(49,954)**	**(56,369)**	**(6,414)**	**(8,202)**	**(9,219)**	**(1,017)**	**(9,549) ▲**	**330**
TOTAL EXPENDITURE	**(323,627)**	**(161,510)**	**(177,369)**	**(15,858)**	**(27,725)**	**(29,108)**	**(1,383)**	**(30,180) ▲**	**1,073**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**44,038**	**17,999**	**12,928**	**(5,071)**	**7,823**	**8,483**	**660**	**3,107 ▲**	**5,376**
Interest Receivable	360	180	691	511	30	90	60	108 ▼	(18)
Interest Payable	(687)	(343)	(335)	9	(57)	(73)	(16)	(26) ▼	(47)
Depreciation, Impairments & Profit/Loss on Asset Disposal	(16,622)	(8,194)	(8,195)	(1)	(1,377)	(1,377)	(0)	(1,514) ▲	137
Donated Asset Depreciation	(622)	(306)	(305)	1	(51)	(51)	0	(50) ▼	(1)
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0 ▲	0
DEL Impairments	(560)	(280)	(280)	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**	**9,055**	**4,504**	**(4,551)**	**6,321**	**7,025**	**703**	**1,577 ▲**	**5,447**
Dividends Payable	(6,007)	(3,004)	(3,006)	(2)	(501)	(501)	(0)	(501) ▲	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**19,900**	**6,052**	**1,498**	**(4,553)**	**5,821**	**6,524**	**703**	**1,076 ▲**	**5,447**

Statement of Cash Flow
As of 30th September 2023

	Mth12 2022-23 £000	Mth 6 £000	Mth 5 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit) from continuing operations	(2,225)	4,426	(2,627)	7,053
Operating (deficit)	**(2,225)**	**4,426**	**(2,627)**	**7,053**
Non-cash income and expense:				
Depreciation and amortisation	14,941	8,500	7,072	1,428
Impairments	1,899	0	0	0
(Increase)/Decrease in Trade and Other Receivables	(8,203)	(5,577)	(1,061)	(4,516)
(Increase)/Decrease in Inventories	(1,096)	10	7	3
Increase/(Decrease) in Trade and Other Payables	(7,239)	(10,245)	(10,364)	119
Increase/(Decrease) in Other Liabilities	(1,935)	2,130	(4,422)	6,552
Increase/(Decrease) in Provisions	420	(325)	(24)	(301)
NHS Charitable Funds	(181)	0	(157)	157
Other movements in operating cash flows	1,730	1	(2)	3
NET CASH GENERATED FROM OPERATIONS	**(1,889)**	**(1,080)**	**(11,578)**	**10,498**
Cash flows from investing activities				
Interest received	871	691	601	90
Addition of ROU assets	(40)	0	0	0
Purchase of intangible assets	(2,673)	90	10,776	(10,686)
Purchase of Property, Plant and Equipment	(25,097)	(14,861)	(17,686)	2,825
Net cash generated (used in) investing activities	**(26,939)**	**(14,080)**	**(6,309)**	**(7,771)**
Cash flows from financing activities				
Public dividend capital received	8,040	2,926	0	2926
Capital element of finance lease rental payments	(2,235)	625	768	(143)
Unwinding of discount	0	(280)	(233)	(47)
Interest element of finance lease	(378)	(335)	(261)	(74)
PDC Dividend paid	(4,760)	(2,638)	0	(2,638)
Receipt of cash donations to purchase capital assets	181	0	157	(157)
Net cash generated from/(used in) financing activities	**848**	**298**	**431**	**(133)**
Increase/(decrease) in cash and cash equivalents	**(27,980)**	**(14,862)**	**(17,456)**	**2,594**
Opening Cash and Cash equivalents	**57,975**	**29,995**	**29,995**	
Closing Cash and Cash equivalents	**29,995**	**15,133**	**12,539**	**2,594**

Appendix 3

Statement of Financial Position as of 30th September 2023

	Mar-23 Audited	Sep-23 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	204.3	216.1	11.8	5.8%
Intangible Assets	19.6	18.4	(1.2)	(6.1%)
ROU Assets	24.4	25.5	1.1	4.5%
Other Assets	3.3	3.3	0.0	0.0%
Total Non Current Assets	**251.6**	**263.3**	**11.7**	**4.7%**
Assets Current				
Inventory	5.2	5.2	0.0	0.0%
NHS Receivables	9.8	13.2	3.4	34.7%
Other Receivables	6.0	8.2	2.2	36.7%
Cash	30.0	15.1	(14.9)	(49.7%)
Total Current Assets	**51.0**	**41.7**	**(9.3)**	**(18.2%)**
Liabilities Current				
Interest -bearing borrowings	(1.8)	(0.8)	1.0	(55.6%)
Deferred Income	(18.0)	(20.1)	(2.1)	11.7%
Provisions	(2.8)	(2.5)	0.3	(10.7%)
Trade & other Creditors (incl NHS)	(51.5)	(46.0)	5.5	(10.7%)
Total Current Liabilities	**(74.1)**	**(69.4)**	**4.7**	**(6.3%)**
Net current assets	**(23.1)**	**(27.7)**	**(4.6)**	**19.9%**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(22.7)	(25.4)	(2.7)	11.9%
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)**	**(28.2)**	**(2.7)**	**10.6%**
Total Assets Employed	**203.0**	**207.4**	**4.4**	**2.2%**
Taxpayers Equity				
Public Dividend Capital (PDC)	283.2	286.1	2.9	1.0%
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)	(136.6)	1.5	(1.1%)
Total Taxpayers Equity	**203.0**	**207.4**	**4.4**	**2.2%**

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
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

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Board Report	**Date: November 2023**
Report Title	Workforce Report – Month 6	**Agenda Item Number: 17**
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 30 September 2023 (Month 6) 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	This is the first version of this report
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 30 September (Month 6), covering the preceding 13 months.

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

Indicator	Measure	Target	09/2022	10/2022	11/2022	12/2022	01/2023	02/2023	03/2023	04/2023	05/2023	06/2023	07/2023	08/2023	09/2023
Staff in post *(as at report date)*	Actual WTE		3458.0	3467.9	3507.1	3524.8	3572.5	3605.1	3618.5	3636.0	3697.4	3710.4	3776.8	3744.1	**3758.3**
	Headcount		3946	3956	4001	4018	4075	4107	4142	4165	4206	4222	4293	4261	**4278**
Establishment *(as per ESR)*	WTE		3881.4	3887.9	3892.8	3892.4	3908.4	3909.8	3907.7	3951.1	3956.4	3956.0	3963.2	3965.5	**3962.0**
	%, Vacancy Rate - Trust Total	**10.0%**	10.9%	10.8%	9.9%	9.4%	8.6%	7.8%	7.4%	8.0%	6.5%	6.2%	4.7%	5.6%	**5.1%**
	%, Vacancy Rate - Add Prof Scientific and Technical		31.3%	33.7%	32.2%	32.5%	32.7%	33.2%	33.2%	31.2%	24.4%	24.4%	25.6%	25.1%	**20.6%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA**s)*		10.1%	10.7%	11.2%	9.0%	12.2%	11.3%	7.7%	9.3%	6.4%	5.3%	0.3%	3.1%	**3.4%**
	%, Vacancy Rate - Administrative and Clerical		8.1%	8.8%	7.6%	7.5%	5.5%	5.4%	5.0%	4.3%	3.0%	3.0%	2.8%	3.1%	**3.7%**
	%, Vacancy Rate - Allied Health Professionals		18.9%	17.8%	16.7%	16.4%	13.6%	12.7%	12.0%	13.6%	16.5%	17.4%	17.1%	15.3%	**16.9%**
	%, Vacancy Rate - Estates and Ancillary		11.5%	10.4%	9.0%	9.5%	8.3%	8.3%	8.6%	11.9%	8.4%	7.2%	6.2%	7.0%	**7.8%**
	%, Vacancy Rate - Healthcare Scientists		0.0%	0.7%	0.0%	1.8%	4.0%	1.7%	1.7%	1.8%	6.3%	9.3%	6.2%	6.1%	**6.0%**
	%, Vacancy Rate - Medical and Dental		0.0%	0.0%	0.0%	0.0%	0.7%	0.8%	3.9%	2.9%	0.0%	0.0%	0.0%	1.4%	**0.4%**
	%, Vacancy Rate - Nursing and Midwifery Registered		15.3%	14.6%	12.8%	12.2%	9.3%	7.4%	7.1%	7.9%	7.7%	7.1%	7.6%	6.2%	**4.3%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		14.8%	15.1%	15.3%	15.6%	15.7%	15.7%	15.3%	15.3%	15.3%	15.1%	14.8%	14.5%	**14.0%**
	%, Temp Staff Usage (%, WTE)		14.2%	14.4%	14.4%	14.5%	14.5%	14.5%	14.5%	14.3%	14.3%	14.2%	14.0%	13.8%	**13.5%**
Absence (12 months)	%, 12 month Absence Rate	**5.0%**	5.4%	5.3%	5.3%	5.2%	5.0%	4.9%	4.8%	4.7%	4.7%	4.6%	4.5%	**4.5%**	*4.5%*
	- %, 12 month Absence Rate - Long Term		*2.8%*	*2.6%*	*2.6%*	*2.5%*	*2.5%*	*2.4%*	*2.4%*	*2.4%*	*2.4%*	*2.4%*	*2.3%*	***2.4%***	*2.4%*
	- %, 12 month Absence Rate - Short Term		*2.6%*	*2.7%*	*2.7%*	*2.7%*	*2.5%*	*2.5%*	*2.4%*	*2.3%*	*2.3%*	*2.2%*	*2.2%*	***2.2%***	*2.1%*
	%,In month Absence Rate - Total		4.2%	5.0%	4.7%	5.0%	4.1%	4.0%	4.1%	4.0%	3.9%	3.9%	4.2%	**4.0%**	*4.1%*
	- %, In month Absence Rate - Long Term		*2.3%*	*2.3%*	*2.6%*	*2.7%*	*2.4%*	*2.5%*	*2.2%*	*2.3%*	*2.3%*	*2.5%*	*2.4%*	***2.3%***	*2.2%*
	- %, In month Absence Rate - Short Term		*1.9%*	*2.7%*	*2.1%*	*2.3%*	*1.7%*	*1.5%*	*1.9%*	*1.6%*	*1.6%*	*1.4%*	*1.8%*	***1.7%***	*1.9%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters (In-month)		59.4	49.2	49.1	54.1	65.5	52.5	61.8	46.8	62.6	44.0	73.3	35.6	**56.0**
	Headcount, Starters (In-month)		68	58	55	60	76	55	65	53	71	52	83	42	**62**
	WTE, Leavers (In-month)		52.9	51.2	27.9	41.7	41.6	25.2	45.3	22.6	25.4	33.8	41.8	37.2	**45.4**
	Headcount, Leavers (In-month)		60	62	35	48	48	29	52	27	30	40	47	42	**58**
	%, Leaver Turnover Rate (12 months)	**12.5%**	15.8%	16.9%	16.9%	17.1%	17.2%	16.7%	16.4%	15.3%	14.9%	14.9%	14.4%	14.1%	**14.1%**
Statutory/Mandatory Training	%, Compliance	**90%**	92%	93%	93%	94%	94%	93%	94%	95%	95%	95%	96%	95%	**95%**
Appraisals	%, Compliance	**90%**	91%	92%	92%	92%	91%	90%	91%	89%	91%	93%	93%	91%	**90%**
Time to Hire (days)	General Recruitment	**35**	56	54	53	48	50	43	41	43	51	49	50	43	**50**
	Medical Recruitment (excl Deanery)	**35**	73	63	80	33	67	59	87	78	70	75	49	51	**53**
Employee relations	Number of open disciplinary cases		15	22	26	22	24	23	20	19	19	13	13	16	**19**

2.1. **Temporary staffing usage** continues to reduce, now at 13.5% with a 1.8% improvement in cost from the beginning of the financial year. 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, the longline bank and agency form is going live in M7. Bank usage is also under review with rostering permissions being revised to ensure there is management authorisation.

2.2. The Trust's **headcount continues to increase** and there are now 4278 employees in post. The fall in headcount in August was due to low numbers of new starters over the summer, which is typical for that time of year. Many newly qualified staff start their role in September/October and the final cohort of international nurses arrived in M6, so the headcount is likely to increase again in M7. The **vacancy rate** has therefore fallen again and is down to **5.1%**.

2.3. **Staff absence is at 4.1% in month** which is a slight decrease from the previous month. The CIPD are reporting record numbers of absence levels across all sectors due to stress and anxiety and there has been an increase in management referrals to Occupational Health for this reason. The increase in absence is due to raised short-term absence as the Trust enters cold and flu season, with an increase in community prevalence of Covid. Managers continue to support staff back to work in line with our sickness absence and attendance policy.

2.4. **Staff turnover** continues to remain at **14.1%**, its lowest point for over 12 months. Retention projects in areas of high turnover continue.

2.5. **Time to hire** has increased to 50 days and the manageable delays in processes are being reviewed to close the timeline where possible.

2.6. The number of **open disciplinary cases** has started to increase again. A detailed Employee Relations case report is produced monthly to JCNC and an annual report was presented to Workforce Development and Assurance Committee.

2.7. **Statutory and mandatory training** compliance is at 95% and **appraisals** compliance is at 90%. Medicine, Surgery and Corporate Services have dipped below the appraisal compliance KPI in M6 and Divisions are asked of assurance and action plans for recovery.

2.8. There are **26.3 nursing vacancies** across the Trust. The fourth cohort of the 2023 intake of internationally educated nurses arrived in M6, consisting of 23 nurses. Focussed recruitment on the remaining nurse vacancies is taking place.

2.9. There are **101 HCSW vacancies** (B2 and B3 and including Maternity Support Workers) across the Trust. The HCSW Steering Group is identifying ways of improving onboarding and training for this staff group to better support retention. The induction checklist is currently being piloted to support good local induction. As in previous years, fierce competition for employees within this pay bracket is expected in the lead up to Christmas.

3. Continuous Improvement, Transformation and Innovation

3.1. The **HR Team** have launched the staff consultation on how the Trust pays staff on Agenda for Change Terms and Conditions whilst they are on annual leave. Currently staff receive a fixed percentage, called 'Working Time Directive Payment' (WTD) on payslips, on top of their pay

for enhanced hours when at work and then receive basic pay when they take annual leave. From 1st April 2024 it is proposed that, to be in line with the Agenda for Change Handbook, the WTD payment will cease and employees will be paid what they would have received if they had been at work, based on the nationally agreed average calculation. The 45-day consultation ends in December.

3.2. The **GMC National Training Survey** results have been released to the Trust. Significant improvements across Paediatrics have been noted and areas for improvement of learning culture have been identified. Action plans were submitted in early October for feedback.

4. Culture and Staff Engagement

4.1. **Staff appreciation week** ran in the first week in October and goody boxes filled with fruit and sweet and savoury treats were distributed to wards and departments to say thank you for their hard work as we move into Autumn and Winter.

4.2. The **staff survey** has launched 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.

4.3. The **Appraise with Values** toolkit and new appraisal paperwork is starting consultation in M8 with planned implementation in Q4. The team have engaged with clinical colleagues to ensure the appraisal paperwork is easier to complete and that managers are more effective at giving feedback and identifying support for progression.

4.4. The Workforce Team continues to triangulate data from various sources and utilises staff feedback to identify themes for areas of improvement. Once an issue/area has been identified the team commission appropriate **improvement programmes**, such as the recent culture awareness programme concluded in IT, alongside the action plans in place as a result of the **annual staff survey listening events**.

5. Current Affairs & Hot Topics

5.1. The HR Services Team are currently reviewing the use of an app called **'Loop'** which is owned by Allocate and will enable staff to **connect to work colleagues**, join team groups, **book shifts**, request leave, view Trust news and messages, get important **Trust notifications** and take surveys. The functionality is currently under review and the team are working with the Communications Department on its interoperability with other Trust software.

5.2. The HR and OD Team are launching **'Courageous Conversations'** training for managers in M8 to support them in how to respond effectively to team members that wish to **raise a concern**. The focus will be on how to listen actively, respond, and act in order to improve the listening culture of the organisation.

5.3. October is **Black History Month** and **Freedom to Speak Up Month.** There have been multiple events in October, including an event in the tent which saw live music, jewellery-making, and a stand from the learning and development team. The closing ceremony will include an engagement session on Teams to listen to lived experiences.

6. Recommendations

6.1. Members are asked to note the report.

Meeting Title	Board Report	**Date: November 2023**
Report Title	Freedom to Speak Up Update – 6m 2023/24	**Agenda Item Number: 18**
Lead Director	Danielle Petch, Chief People Officer	
Report Author	Philip Ball, Lead Freedom to Speak Up Guardian	

Introduction	This report provides an update on FTSU activity for the period 1 April – 30 September 2023		
Key Messages to Note	Referrals to FTSU have increased. The themes are generally around intolerance of poor behaviours. Recruitment to the Champions role is planned for Q3 and Q4. A business case is in progress for increased hours for the Lead Guardian.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☒	**For Approval** ☐	**For Review** ☐

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

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

Freedom to Speak Up
Bi-Annual Report
1 April - 30 September 2023

Philip Ball
Lead Freedom to Speak Up Guardian
October 2023

Contents

1. Executive Summary 4
2. Introduction 5
3. FTSU Team....5
4. Analysis of FTSU Activity 6
4.1. Findings by Case Type....7
4.2. Themes....8
5. FTSU Team Activity Update....9
6. National/Regional Update 9
7. Audit & Governance 9
7.1. CQC Readiness Update 10
7.2. Local FTSU Self-Assessment Update 10
8. Recommendations 10
9. Appendix 1 Data charts....11

1. Executive Summary

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

In the 6-month period from 1st April to 30th September 2023 there have been 66 new concerns raised to the FTSU Team. For the majority of cases where the witness has asked for support and intervention from the Guardian, the case has been dealt with through FTSU intervention with line managers or support from the Human Resources teams. Each witness has their own case number and there may be several witness allegations or concerns raised that relate to one individual.

The team have started to collect more data from those speaking up, however due to concerns of anonymity, witnesses are often unwilling to have their details documented. This has made collation of witness name, respondent name, and any witness' protected characteristics particularly challenging. Without this data being consistently given for each case, it is difficult to identify trends and themes. Where the witness is unwilling to name the person they are raising a concern about, their case outcome cannot be tracked through formal HR processes. Changes to the way cases are referred to the FTSU team through the use of the FTSU App, will help improve data collection and analysis once it has been rolled out.

2. Introduction

This report outlines the FTSU activity for the Trust between 1st April 2023 and 30th September 2023. The data is sourced from the confidential log kept by the Guardians which acts as the Trust's FTSU record system. The log stores information about each case and groups cases by type. The case types as defined by the NGO are:

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

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

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

3. FTSU Team

Guardians details:

Guardian f/t or p/t	Hours per week	Role	Professional background
1 x p/t paid	15 hours	Lead FTSU Guardian	Nursing
2 x p/t protected time	0.5 day per week	FTSU Guardian	Nursing
1 x p/t protected time	0.5. hours per week	FTSU Guardian	Physiotherapist
1 x p/t protected time	0.5. hours per week	FTSU Guardian	SOPD Theatres

The Guardians are supported by 12 Champions, including 9 trained and recruited in June and July 2023, who act as first points of contact and signposts to Guardians where required. Two Champions have left the group due to work commitments and one has left the Trust.

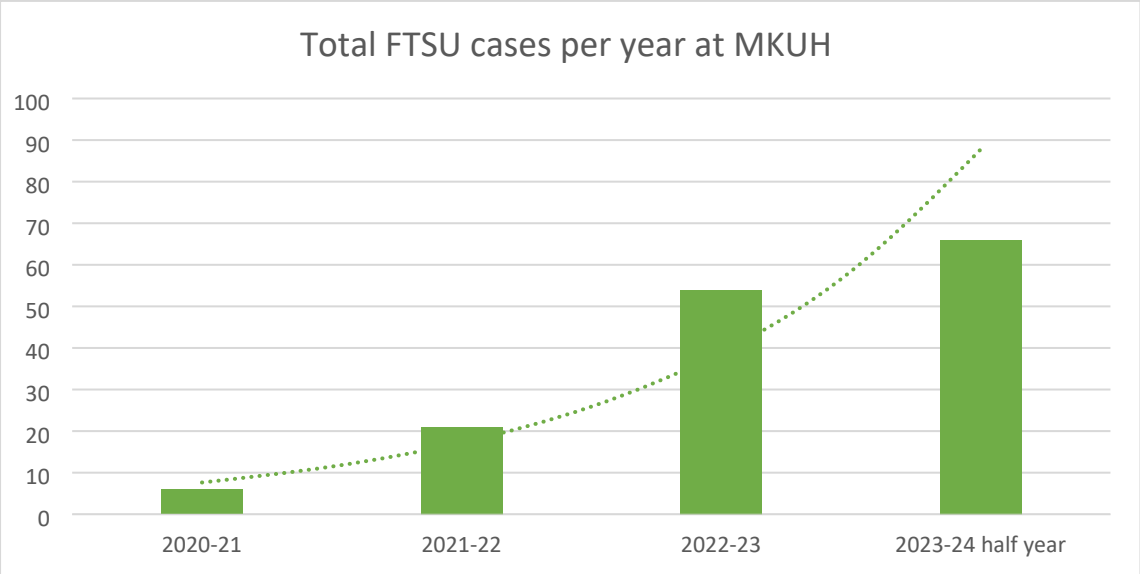
The entire team cover a range of roles including clinical, (nursing, therapies and ODP), administrative and support services. They include one MKUH network Chair.

During 2023 the Guardians have set meetings every month in order to keep in touch with developments and receive support and training. This includes the opportunity for updates on policies via a HR Business partner.

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

4. Analysis of FTSU Activity

The cases reported for the period has shown a significant increase with 66 new cases in the first 6 months, already overtaking the 54 case total for 2022-23.



The charts (see Appendix 1) show the areas, case types[1], and staffing categories[2] of cases raised so far. Surgery has the most at 27, followed by Core Clinical with 18. Neither CSU nor Department level data is currently recorded. Inappropriate attitudes and behaviours and worker safety and wellbeing both totalled 19 cases each. Bullying and harassment had 14 cases. Nurses and Midwives were the highest reporting group with 19 cases, followed by Allied Health professionals with 15 cases.

From 1st April the Guardians have started collating data from those speaking up on several protected characteristics including ethnicity, age range, disability status, and gender. As the reporting of this data continues, it will help us identify groups who are more likely to speak up and help identify trends by Division and Case Type. The team have recently started collecting data on which department the person speaking

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

up works in. Less than half of witnesses have shared their protected characteristic data.

Of the 66 cases only five witnesses have named a respondent. Out of these, two of the respondents are being investigated formally through an HR process, one has been dealt with through line management and two have decided not to progress their case.

4.1. Findings by Case Type

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

Worker safety and wellbeing = 19 cases. The most common theme is on wellbeing which can range from reports of violence and aggression, to feeling stressed and unable to carry on working with a particular colleague.

Inappropriate behaviours or attitudes = 19 cases. These cases consist of a broad category of examples, where colleagues have talked over others or ignored them based on their role.

Bullying or harassment = 14 cases. These cases range from reports of feeling forced into bank work, being exposed to upsetting comments from colleagues or senior managers.

Disadvantageous and/or demeaning treatment (Detriment) = 8 cases. These cases consist of where a witness has raised an issue to their manager and then this act has had a detrimental impact on their working relationships.

Patient safety/quality = 6 cases. These cases have been related to indirect concerns of possible patient safety, for example where staffing levels are raised as a concern with the suggestion that this is impacting on patient safety. The Guardians work closely with the Patient Safety Team to enable sharing of concerns and data to ensure patient safety has not been compromised. This category has been used for cases where there is a potential negative impact on patient care. No cases have been raised in the period where there has been patient harm. Guardians know they have a responsibility to report any immediate risk to patient safety to the appropriate senior clinicians and safeguarding as required.

4.1.1 Equality and Diversity Data

Gathering data on protected characteristics has been a new objective for the Guardians. Less than half of witnesses declare their protected characteristics, the data collated since April 2023 is in Appendix 1. BAME colleagues make up 40% of the workforce however only 31% of those recorded as speaking up are from a BAME

background. You are more likely to speak up to the FTSU Guardians if you identify as male.

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

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

4.2. Themes

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

This review has identified the following themes and trends:

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

Work is currently underway to triangulate outcomes from concerns raised with HR data so that progress reports and activity can be shared with the Trust to reassure that action is taken.

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

5. FTSU Team Activity Update

The FTSU team have trained and recruited more Champions and plans are being developed for further Champion training dates with areas such as the paediatrics and neonatal teams. The recruitment process is currently being mapped out to develop a robust and fair approach, with a focus on building the number of Champions and developing them into Guardians after a set period of time and where there is enthusiasm to take on the role.

Guardians hold regular confidential catch-up sessions with each other to ensure our own wellbeing and to give support. The Champions are supported in groups by each Guardian, again to offer support and encouragement. October is the NGO Speaking Up month with the theme of #BreakingFTSUBarriers. Plans are underway for activity with the BAME network for a joint event in speaking up and sharing lived experiences. Working with Communications to plan FTSU activity for the coming year will ensure that there is publicity in place to support good attendance at the events.

6. National/Regional Update

The NGO provides regular updates and is working to emphasise the importance of speaking up in the light of the Countess of Chester Hospital case. Jayne Chidgey-Clark, the National Guardian, is clear that Guardians and FTSU are 'not the panacea for the ills of the NHS but an additional route for people to raise concerns and only part of the solution'. The NGO encourages cultural change work to take place, particularly to make sure selection, recruitment, and retention are focused on appointing people with the required values.

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

7. Audit & Governance

An opportunity to use a questionnaire for MKUH employees and workers to complete regarding FTSU is planned for Q4. Oversight of the FTSU service is done through meeting the Deputy Chief People Officer. Feedback is sought from those who speak up through a feedback form for the service and of those returned the feedback is 100% positive.

7.1. CQC Readiness Update

The Lead Guardian has engaged with the Trust CQC Preparedness Board meetings. The Speaking Up policy has been reviewed and updated based on the NHSE template policy dated 2022. Whilst senior leaders and the lead Guardian would be

interviewed by the CQC, they will also interview staff at all other levels about access to, and value of FTSU at the Trust. It will be expected by the CQC that managers will be able to describe the 'Speak Up, Listen Up and Follow Up' processes that are highlighted in the training modules. The Trust is currently at 97% compliance for Freedom to Speak Up Training.

7.2. Local FTSU Self-Assessment Update

Each year the Executive Lead for FTSU completes a review of local Trust FTSU activity and processes against a national self-assessment toolkit. Following this an action plan is devised to amend processes and procedures as required. Progress against the action plan this period is -

- Implementation of the NGO eLearning for all staff, on the three modules of 'Speak Up, Listen Up, and Follow Up'
- The Speaking Up policy was reviewed to ensure compliance against the national policy and revised incorporating the NHSE model.
- Increased numbers of Champions

Progress planned next period is -

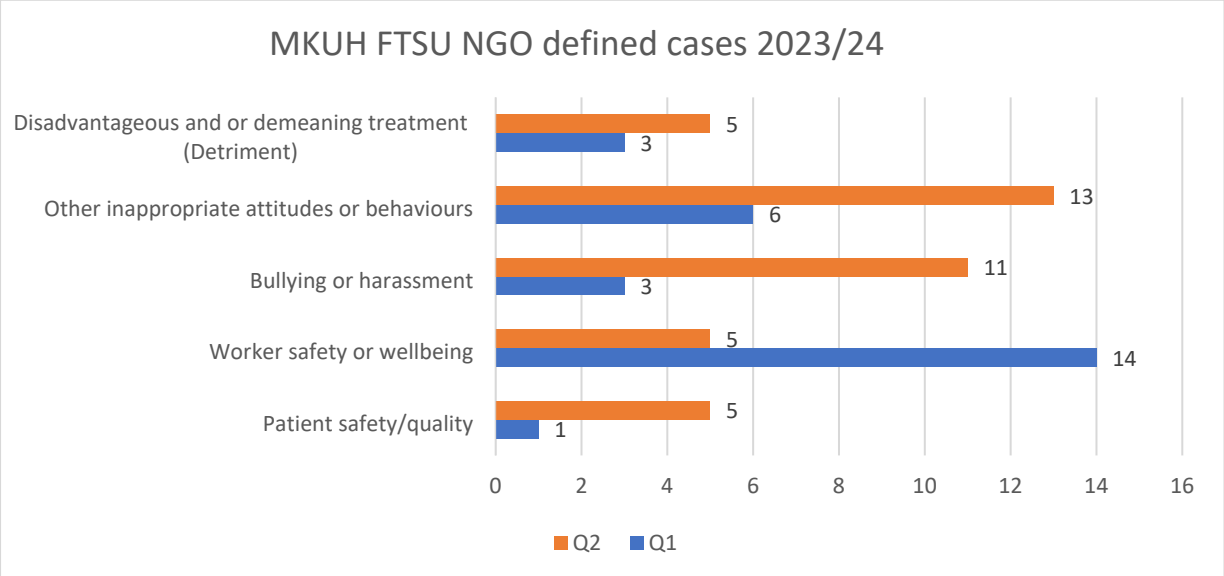
- New Guardians and Champions to be recruited
- Business case submission for an increase in the employed Lead Guardian's hours
- Training for the Guardians and Champions on HR processes
- Introduction of Courageous Conversations training for leaders and managers on the soft skills needed for listening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

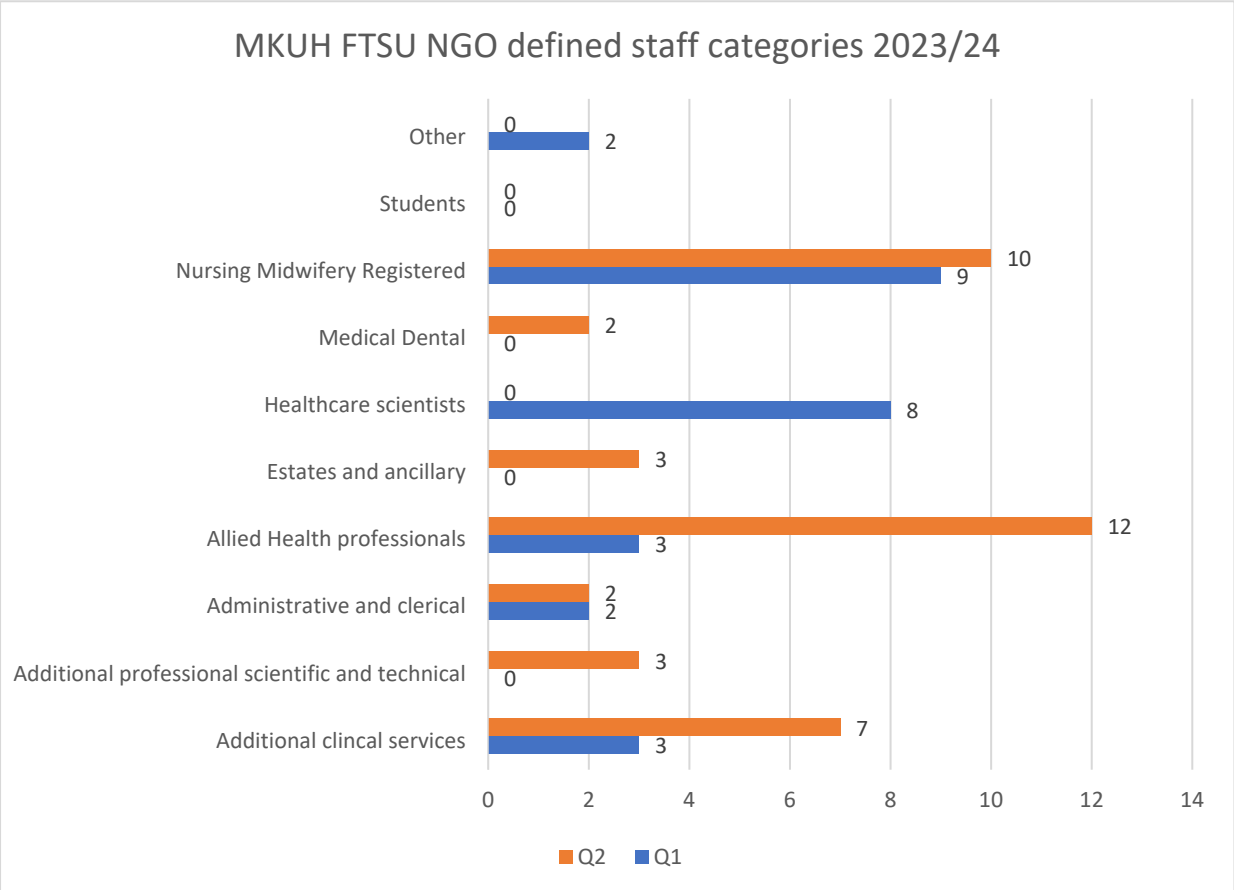
Completed actions include regular meetings with the Deputy Chief People Officer, sharing data with HR Business Partners and a FTSU presence in management training and staff induction sessions.

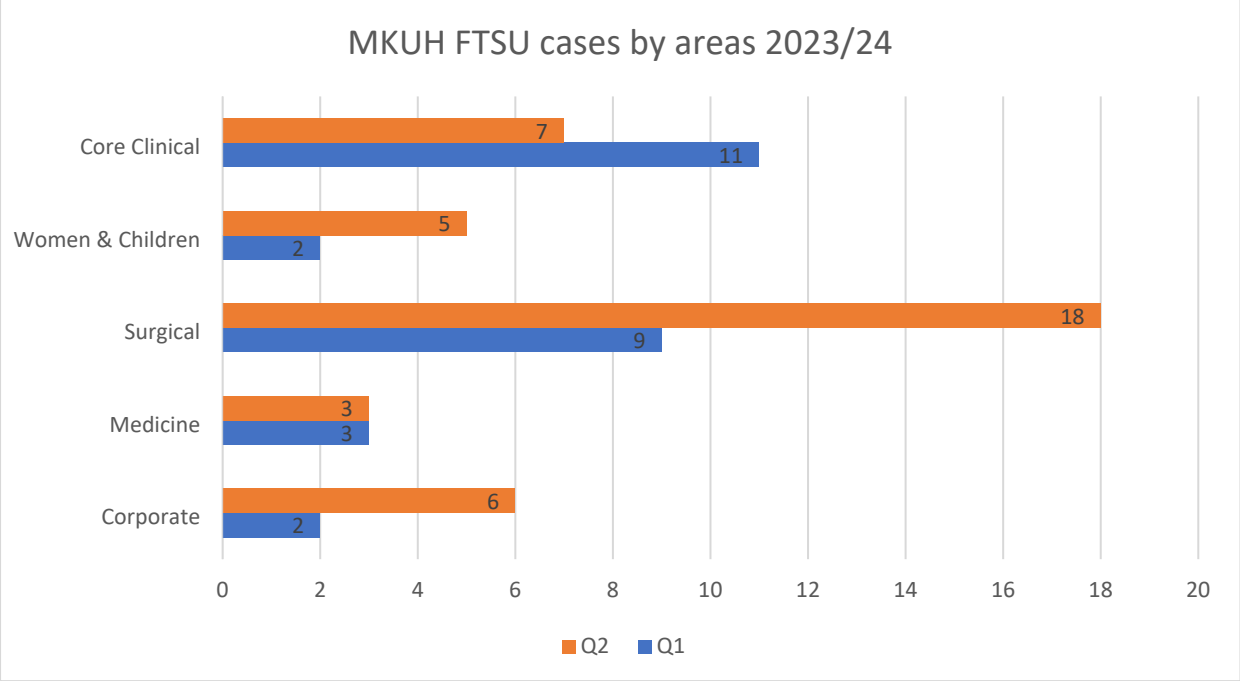
8. Recommendations

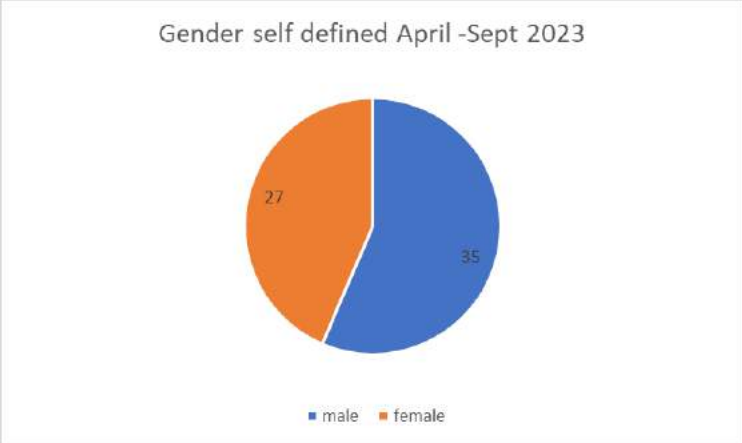
Board members are asked to note the contents of this report and the actions listed.

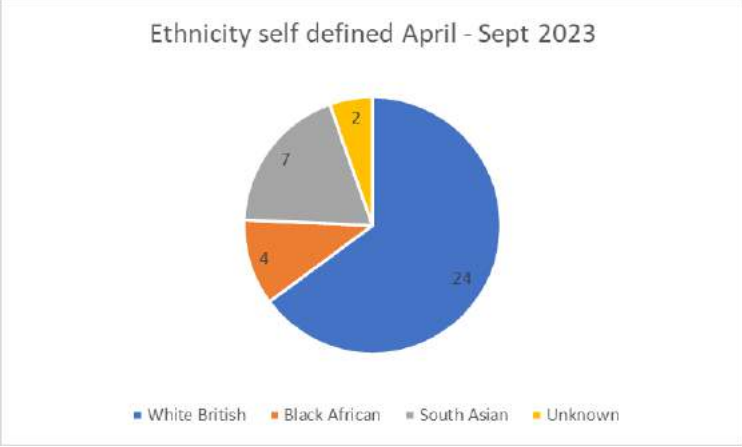
Appendix 1 Data Charts

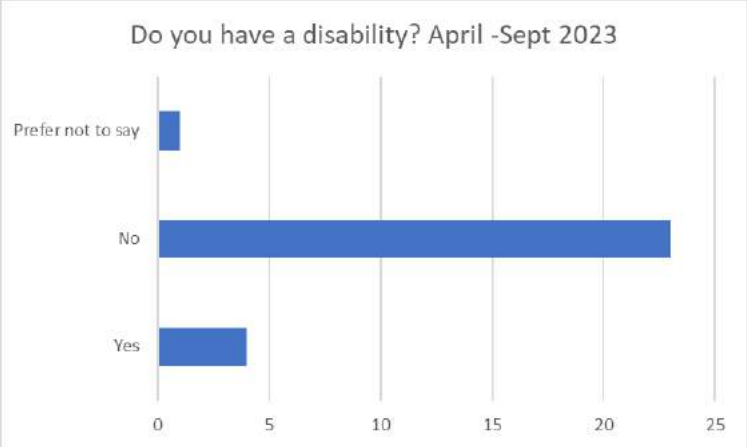


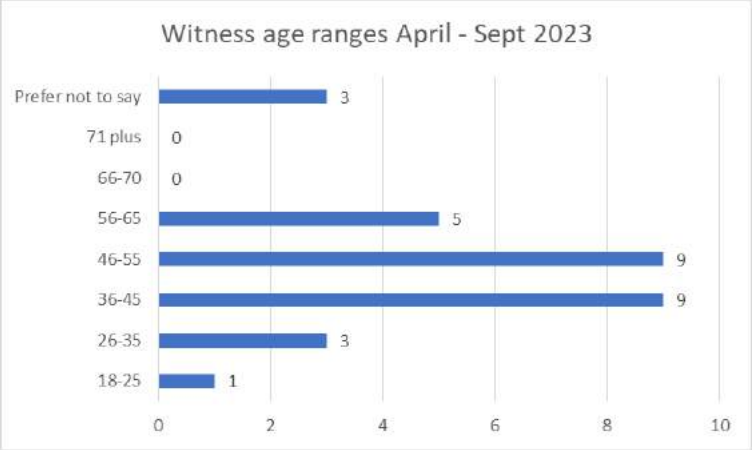



MKUH FTSU cases by areas 2023/24
Core Clinical
Women & Children
Surgical
Medicine
Corporate
7
11
5
2
18
9
3
3
6
2
0
2
4
6
8
10
12
14
16
18
20
Q2
Q1


Gender self defined April -Sept 2023
27
35
male
female


Ethnicity self defined April - Sept 2023
2
7
4
24
White British
Black African
South Asian
Unknown


Do you have a disability? April -Sept 2023
Prefer not to say
No
Yes
0
5
10
15
20
25


Witness age ranges April - Sept 2023
Prefer not to say
71 plus
66-70
56-65
46-55
36-45
26-35
18-25
3
0
0
5
9
9
3
1
0
2
4
6
8
10

TheMKWay

Annual Report on Infection Prevention and Control, for the period April 2022 – March 2023

NHS
Milton Keynes University Hospital
NHS Foundation Trust

TheMKWay

Contents:	Page:
Abbreviations	3
Executive summary	4
Introduction	5
Hygiene code- criterion 1-10	6
1. Systems to manage and monitor the prevention and control of infection	7
2. Provide and maintain an appropriate environment in managed premises that facilitates the prevention and control of infections	17
3.Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance	22
4.0 Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care, in a timely fashion	23
5.0 Ensure that people who have, or develop infection are promptly identified, appropriately treated and the risk of transmission to others is addressed	24
6.0 All care workers, this includes contractors, and volunteers are aware of, and discharge their responsibilities for processes that prevent and control infection	24
7.0 Provide or secure adequate isolation facilities	25
8.0 Secure adequate access to appropriate laboratory support	26
9.0 Have and adhere to policies designed for individual care and provider organisations that support prevention and control of infection	26
10 Ensure, so far as is reasonably practicable, that care workers are free of and protected from exposure to infection that can be contracted at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care	27
Key areas of focus 2023/24	27
Conclusion	28
References	29
Appendix 1. *Clostridiodes difficile*	30
Appendix 2. Reinvesting in hydration, continence, dip tests, catheters, and AMS to improve patient experience, outcome and reduce E. coli infection	33

Abbreviations:

AHP	Allied Health Professionals
AMR	Antimicrobial Resistance
AMS	Antimicrobial Stewardship
CDI	*Clostridioides difficile*
CEO	Chief Executive Officer
COCA	Community Onset Community Associated
COHA	Community Onset Healthcare Associated
COIA	Community Onset Indeterminate Association
CPE	Carbapenemase producing *Enterobacteriaceae*
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
E. coli	*Escherichia coli*
EPR	Electronic Patient Record
HCAI	Healthcare Associated Infection
HOHA	Hospital Onset Healthcare Associated
ICD	Infection Control Doctor
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IPCT	Infection Prevention & Control Team
MKUH	Milton Keynes University Hospital NHS Foundation Trust
MRSA	Meticillin Resistant *Staphylococcus aureus*
MSSA	Meticillin Sensitive S*taphylococcus aureus*
NHSE/I	National Health Service England/Improvement
OHWB	Occupational Health and Wellbeing Department
PCR	Polymerase Chain Reaction
PHE / UKHSA	Public Health England / UK Health Security Agency
PIR	Post Infection Review
PLACE	Patient-Led Assessments of the Care Environment
PPE	Personal Protective Equipment
PVC	Peripheral Venous Cannula
WSG	Water Safety Group

Executive Summary.

Infection Prevention and Control (IPC) is the responsibility of everyone in our hospital and its successful outcomes reliant on our collective understanding and application of avoidance measures.

Over the last 12 months, whilst reducing in its pressure, we have continued to support the ongoing management of Covid -19 with the provision of a dedicated patient assessment and management area (ward 8) and to review staff competency in ensuring the correct use of personal protective equipment alongside delivery of appropriate clinical care in line with national guidance.

The Milton Keynes University Hospital NHS Foundation Trust (hereafter referred to as "MKUH") strives to maintain overall compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (more often referred to as the Hygiene Code) (Department of Health, 2015), although there remain some areas for improvement and optimisation.

The Infection Prevention and Control Annual Report continues to follow the format of the Health & Social Care Act 2008 (updated 2015) to demonstrate our progress with the requirements associated with the criteria of the Act and in offering assurance to the Board of substantial progress being made throughout the year.

The report is mapped against the ten criteria of the 'Hygiene Code' and takes the opportunity to celebrate successes and highlight the increasing challenges going forward:

1. We reported 1,757 positive Covid-19 results during 2022/23, however, not all of these required a hospital admission as they may have been managed in the community or were tested prior to an elective procedure. In total, we received 14,034 swabs to test for Covid-19 during the reporting timeframe.

2. We have not been able to confidently identify the number of positive Covid-19 results in staff from the 1,757 but can relate to the challenges associated with staff absence due to Covid-19 when staffing clinical and non-clinical services.

3. There have been 2 hospital onset healthcare associated MRSA bacteraemias in 2022/23 and 5 community onset-healthcare associated MRSA bacteraemias. All have been investigated.

4. The Trust reported 19 hospital onset healthcare associated and 36 community onset healthcare associated *Clostridioides difficile* cases to give a total of 55 cases for the year.

5. Surgical site infection surveillance has continued uninterrupted within the knee, and hip categories, and caesarean section deliveries. The latter is a local monitoring programme.

6. Uptake of Covid-19 vaccination in staff was 60.1%, with influenza immunisation reaching 73% with all data recorded on the National Immunisation and Vaccination System (NIVS).

7. Covid-19 restrictions in the community are believed to have been instrumental in a reduced prevalence of other viral pathogens, namely Norovirus and Influenza. In 2022/23, there were no flu outbreaks identified in our hospital setting, but some bay/ward closures due to Norovirus.

8. The annual deep cleaning programme has continued despite capacity pressures in addition to Covid-19. An ongoing theme during the weekly assurance rounds by the multidisciplinary teams are of structured decluttering, commissioning minor estates work, such as repairs to wall damage, or making good breaches to paintwork, repairing damaged flooring, cleaning light fittings and or the removal of fixed radiator covers to enable cleaning.

9. Processes for the decontamination of medical devices, reusable invasive instruments and hospital linen are all undertaken to national standards. (linen is processed off site).

10. The Trust has safe water systems with a planned programme of work to ensure that concerns are identified promptly, actioned effectively, and resolved efficiently.

11. The Trust Occupational Health and Wellbeing (OHWB) service remains critical in the delivery of both routine staff health surveillance and vaccination services.

12. Education and training continues through the antimicrobial stewardship rounds, the daily review of patients by the infection control nurses and is combined with e-learning to maintain compliance with IPC training. The programme focuses on general infection prevention and control procedures, hand hygiene, antimicrobial prescribing, aseptic technique, and correct selection, /disposal of personal protective equipment (PPE).

INTRODUCTION

The Infection Prevention and Control (IPC) annual report, written by the associate chief nurse for IPC, provides an update on activities within the Milton Keynes University Hospital NHS Foundation Trust from April 2022 to March 2023.

The publication of the IPC Annual Report is a requirement to demonstrate our commitment to governance, and our adherence to Trust values and public accountability. The purpose is to provide assurance that the Trust strives to achieve and sustain compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015).

We expect, as a minimum, that standard IPC practices are applied consistently and are part of our everyday practice, meaning that people who use our services receive safe and effective care. Avoidable infections can be overwhelming for patients.

This report acknowledges the hard work of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholders experience, as well as helping to reduce the risk of infections. The Trust continues to work collaboratively with a number of external agencies as part of its IPC and governance arrangements.

The author would like to express her appreciation and thanks to Dr Ian Reckless for his mentorship across the months as interim Director of Infection Prevention and Control and all those that helped the Trust adjust to the demands of the last year, as well as acknowledging the contribution of other colleagues to this report.

Table 1.0 The Hygiene Code Compliance Criteria

1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

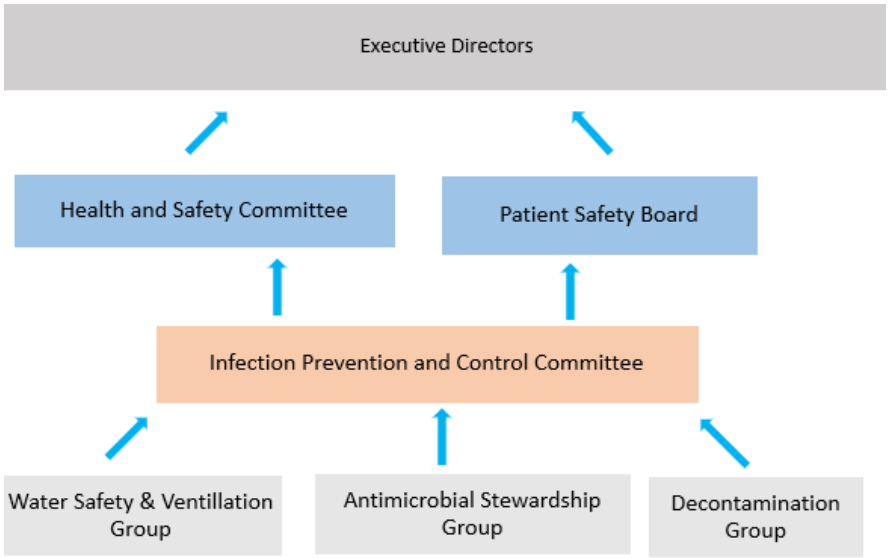
1.0 CRITERION ONE: Systems to manage and monitor the prevention and control of infection.

1.1 **These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.**

1.2 The Trust has in place:

- A Board level agreement outlining their collective responsibility for minimising risks of infection and how this is to be achieved.
- An Infection Control Doctor (ICD) and Director of Infection Prevention and Control (DIPC), reporting to the Chief Executive. The DIPC meets the competencies required for this role. (Department of Health, 2004).
- The Infection Control Doctor supports the Trust Decontamination Lead.
- Systems by which the Board ensures sufficient resources are available to secure effective prevention and control of healthcare associated infection (HCAI).
- Measures to ensure that relevant staff, contractors, and other persons directly or indirectly concerned with patient care receive suitable and sufficient information, training and supervision in measures required to prevent or minimise HCAI.
- A programme of audit, surveillance, and quality improvement to ensure key policies and practices are being implemented appropriately.
- Guidance supporting patient movement between departments, within and between healthcare establishments.
- A designated antimicrobial pharmacist and a consultant microbiologist with an antibiotic stewardship role.

The Infection Prevention and Control Governance Structure



1.3 The Decontamination Group is chaired by the Head of Decontamination Services, Marea Lawford, supported by the Consultant Microbiologist/Infection Control Doctor, Dr Poonam Kapila. The membership ensures representation from support services and senior clinical colleagues.
The group meets quarterly and reports to the Board via the Infection Prevention and Control Committee, highlighting concerns, celebrations, risks, and gaps in assurance.

1.4 The Trust has in place suitable and sufficient assessment of risks to patients receiving healthcare with respect of HCAI. These are benchmarked against national best practice, clinical judgment, and local risk assessment. We recognise gaps in compliance with scheduled review in some areas, assurance is being sought from divisional leads, the expectation being that revised risk assessment are presented to the IPCC.

1.5 Corporate and local HCAI risk assessments are available on the Trust's Risk Register. Existing control measures and further preventative measures are identified for action and monitored through divisional governance meetings. Good practice: the Risk Manager emails a prompt each month to service leads to remind them of upcoming reviews.

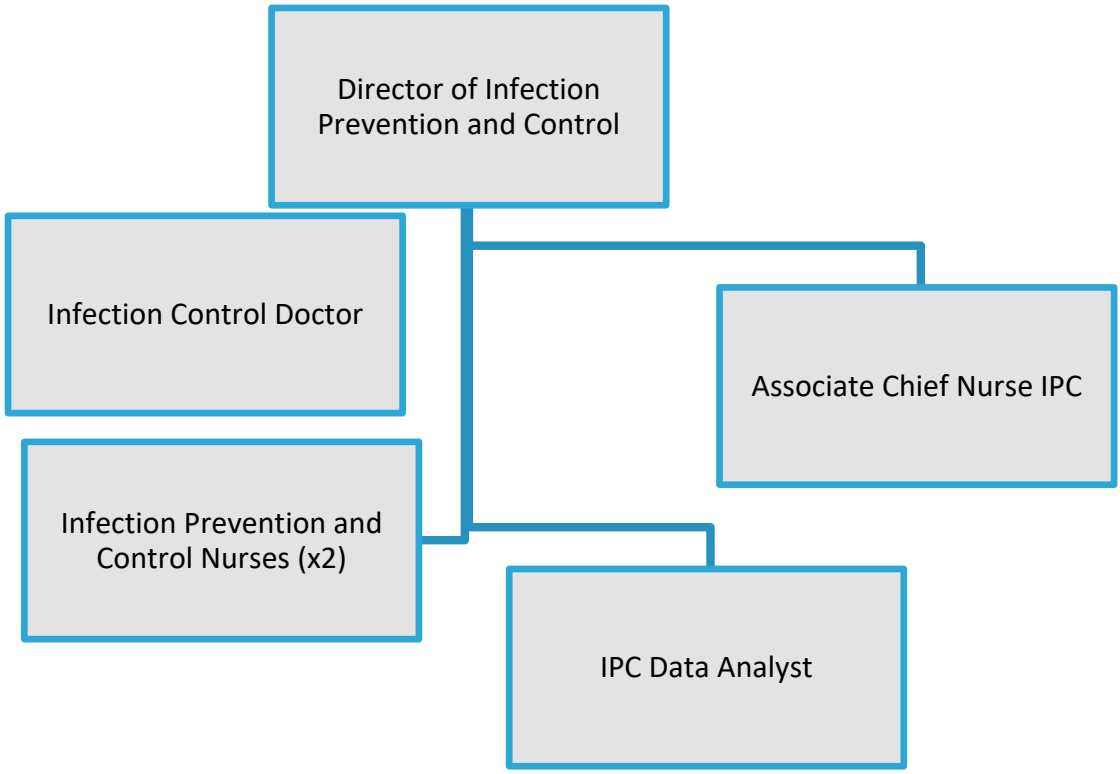
1.6 The Trust has a robust incident reporting system (RADAR) through which staff can report adverse incidents such as deviation from a clinical guideline or poor practice that may be detrimental to patient care. The IPC team have oversight of all incidents and provide expert guidance and advice as required to mitigate any further risk or patient harm. Each MRSA and MSSA bacteraemia is subject to a post infection review (PIR) and is reported via RADAR, as are *Clostridioides difficile* infection (CDI) . All PIR actions identified are disseminated by Matrons at divisional governance meetings. Any deaths occurring within 30 days of a positive CDI result, where the infection is confirmed as contributory to the patient death, is reported as a serious incident in line with the National Framework.

1.7 Every patient diagnosed with MRSA, MSSA bacteraemia or *Clostridioides difficile* is reviewed regularly by a member of a Consultant Microbiologist, antimicrobial pharmacist, infection control nurse and the patient nurse/medical team plus the patient where able, to support correct clinical placement and management through expert advice.

1.8 The Infection Prevention and Control Team (IPCT) comprises a registered and unregistered workforce who assist in delivering the annual programme, providing continuity and consistency of approach for service users who also move between provider services through their care pathway. The team members regularly rotate across the divisions to maintain varied experience, supporting ability to recognise and respond to differing levels of risk, differing needs and can apply their specialist knowledge and skills in a variety of settings.

1.9 One of the three Consultant microbiologists, Dr Poonam Kapila, fulfilled the role of Infection Control Doctor (ICD). Dr Mansoor Raza has a clinical practice in infectious disease and Dr Prithwiraj Chakrabarti is the lead consultant for antimicrobial stewardship. Dr Amarjeet Kaur holds a specialist registrar portfolio and is an active participant in all aspects of clinical microbiology.

The Structure of the Infection Prevention and Control Team



1.10 An onsite daytime IPC nursing service is provided 5 days a week with an on-call service available out of hours during times of outbreak. All nurses who provide the on-call advice service are experienced IPC specialists. There is also 24/7 consultant microbiologist cover. The Trust also shares cross cover (weekends) with the Great Western Hospital, Swindon.

1.11 The antimicrobial stewardship work led by Consultant Microbiologist Dr Chakrabarti has 1 PA job planned specifically for antimicrobial stewardship activities. Working collaboratively with the lead Antimicrobial Pharmacist, Lauren Ramm, they provide leadership to influence and promote the safe and effective use of antimicrobials across the Trust in accordance with local and national guidelines.

1.12 The Antimicrobial Stewardship Group (ASG) is tasked with ensuring that antimicrobial drugs are utilised throughout the Trust in a way, which results in optimal treatment of infections while minimising the risk of adverse effects, including healthcare associated infections. The group is chaired by the Medical Director, Dr Ian Reckless, who has also held the Director of Infection Prevention and Control (DIPC) portfolio across the majority of the reporting period.

1.13 Programmes of work are prepared by the IPCT, ratified by the Board, and mapped to the duties of the Code of Practice to demonstrate continued work in maintaining compliance with the Code. It includes all planned aspects of IPC, including provision of clinical advice, policy development and

review, training, audit, and surveillance. New work streams are added in response to new infections and national guidance, which can impact completion of planned activities.

1.14 Covid -19 has had an impact on every aspect of clinical care in the Trust. The IPCT provided clinical and operational advice and helped implement and embed national guidelines and policies to all departments across the Trust. This fed into the Trust command and control structure that coordinated the Trust response to the pandemic reflecting national policy utilising a silver and gold level model of accountability and decision-making. The infection control team provided expert opinion and advice reflecting the evolving national guidance to inform the Trust IPC strategy.

1.15 Occupational Health and Wellbeing played a key part in identifying and managing declared staff clusters/outbreaks across the Trust.

1.16 Improvements that could be implemented ahead of peaks or predicted surges of highly transmissible infections include:

- Bed moves – moving from ward to ward.
- Vulnerable patients / shielding – and the use of the standardised system flag to indicate shielding/ vulnerability.
- Management of diagnostic requirements – Theatres, Xray, ECHO, MRI etc. (areas working as potential vectors).
- ED Blue/Red box patients admitted and subsequently placed as an inpatient.

The Trust can ably demonstrate its continued commitment to improvement and patient safety through key learning outcomes and recommendations, capacity, and the need to place patients appropriately.

1.17 HR engineered a Covid-19 related absence report supporting the Trust's Covid-19 staff process. This included supporting staff and management with testing and isolation guidance, queries relating to Covid-19 such as criteria for testing/isolation, support and guidance to managers and staff on their Covid-19 risk assessment, vaccination queries, supporting health and wellbeing and national and internal reporting.

Surveillance of Healthcare Associated Infections

1.18 Surveillance is more than just the recording or reporting of infections with data collected in accordance with strict definitions and protocols to ensure consistency. Some surveillance data are only reported internally, and other data are reported externally, either as part of mandatory or voluntary surveillance schemes. However, the most important element of surveillance is feedback to clinicians. Feedback prompts review of, and where necessary, planned improvements to clinical practice. Even where practice appears to be

appropriate, feedback may result in subtle improvements to individual practice that support reduction in rates.

Mandatory Reports

1.19 Mandatory reports are made to the UK Health Security Agency (UKHSA) formerly Public Health England (PHE). These include the reporting of:

- *Staphylococcus aureus* bacteraemia
- *Escherichia coli, Klebsiella and Pseudomonas aeruginosa* bacteraemia
- *Clostridioides difficile*
- Orthopaedic Surgical Site Infection

Nationally mandated financial consequences (usually referred to as “sanctions”) were removed from the NHS standard contract from April 2021.

1.20. Staphylococcus aureus bacteraemia patient-level data is collected and submitted through an on-line data capture system. This was made mandatory for meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia in 2005 but remained voluntary for meticillin sensitive *Staphylococcus aureus* (MSSA) until 2011 when it also became mandatory. The enhanced data set allows distinction to be made between bacteraemia that are hospital or community attributable. It also identifies the care details and risk factor information, which enables improvement to be targeted, which have been effective, but to a lesser extent than aimed for. Targeted work with teams, patients and adherence to policy continues.

2 cases of MRSA bacteraemia were reported for MKUH in the year, one of which may have been avoidable.
(Case 1)

MRSA Case 1: Medicine Potentially avoidable	Elderly male with cognitive impairment admitted from respite care. Mental state rendered compliance and standard care measures (including oral hygiene) very challenging. Gaps identified and learning: 1. Full MRSA screen not undertaken on admission. 2. Observation of cannula (VIP score) incomplete. 3. Oral pus (seen by ENT for parotitis) not sent for microbiological assessment.
	The second MRSA case, also in medicine (different ward – no suggestion of transmission)
MRSA Case 2: Medicine Unavoidable	Presented with hepatitis and acute delirium on return from holiday. Acute delirium and aggression rendered optimal management of a necessary intravenous cannula impossible. Cannula removed once evidence of irritation. May have been precipitated in part by need for manual contact to guide the patient when ambulant and to maintain his safety. Good recovery and discharge home.

1.21 There has been a rise in MSSA bacteraemia compared with previous years but a national threshold is yet to be applied. The MKUH has supported care for a specific cohort of individuals who are associated with substance misuse or identified at risk of self-neglect. Despite best effort, and whilst these cases may appear to the reader as avoidable, no patient education or advice has yet proved successful in subsequent avoidance of repeat bacteraemia once discharged back to the community. We continue to work collaboratively with teams, in Bedford, Luton and Milton Keynes Integrated Care Services (ICS).

The review of MSSA cases for the MKUH. Case 2 was identified as avoidable, as a number of failures/omissions emerged on scrutiny of patient notes, that on their own may not be viewed as harmful but collectively cannot be excluded from being contributory in a less than optimal experience/poor management for this patient.
Actions to improve patient management and experience focus on consistent documentation of MSSA protocol being followed, particularly verification of repeat cultures being taken.
All patient notes in eCARE entries to show insertion, management and timely removal or re-siting of peripheral intravenous access. Greater opportunities for clinical staff to prompt the “IV to Oral” switch of antibiotics will support antimicrobial stewardship and lessen the potential for medical devices to be associated with bacteraemia. The observance and documentation of the visual inspection of phlebitis (VIP) score is much improved, the turnaround influenced by the Matron group, the evidence shared at the daily clinical huddle.

For sustained improvement, our preventative practice must start from the moment we identify the need for a medical device to be inserted, the conversation with the patient as to best arm/hand, the implication for the use and how the patient can optimise safety through their involvement and understanding of the risks. This is the approach we should be evidencing with all medical devices.
Strict adherence to infection control, will reduce patients' susceptibility to a bloodstream infection. Recognising the predominant organisms associated with each clinical setting can prevent mortality as bloodstream pathogens such as *Staphylococcus. aureus*, and *Pseudomonas aeruginosa*.

Prevention also includes the judicious use of antibiotics, which must take into effect the risk and reward of antibiotic use. The rising prevalence of multi-drug-resistant bacteria will continue to exert pressure on our combined effort to reduce HCAI, making education, prevention, and adherence to protocol a necessity to counter the debilitating effects of bloodstream infections.
The key to lowering the morbidity of bacteraemia is the continuing education of our healthcare workers and our patients/carers, and for that to be at the forefront in delivering a consistent safety approach across the interprofessional teams to improve outcomes.

Gram negative bloodstream infection

1.22 Eligible cases of Gram-negative blood stream infection (GNBSI) are reported via the UK HSA data capture system (HCAI DCS). This became mandatory for *Escherichia coli* (*E. coli*) bacteraemia from 2011, and *Pseudomonas aeruginosa* and *Klebsiella* spp. bacteraemia from 2017.

1.23 In 2021/22 the NHS Standard Contract detailed a new operational standard baseline threshold for GNBSI per Trust provider, as published nationally by NHS England and NHS Improvement. These baseline thresholds are presented as counts rather than rates, which aim to minimise the incidence of GNBSI by 5% of the 2019 calendar year total. Trust level thresholds include all healthcare associated cases (HOHA and COHA). It is important to recognise that the UK HSA mandatory surveillance team acknowledge that complete data on healthcare association for GNBSI was not required in 2019 therefore healthcare association for that year was determined through an estimated system based on limited existing NHS electronic records. The more familiar rates per 100,000 bed days were not presented as the operational standard due to changes in hospital bed days seen since the start of the pandemic in 2020, which was deemed to alter the value of utilising those measurements as a means of trend analysis.

1.24 There were 197 *E.coli* bacteraemia reported to the UK HSA HCAI DCS in 2022/23. This is 32 more cases than the year before**. Acute cases = 25 cases** within the reporting year (15 cases previously). Community cases= 172 cases within the same frame (150 previously. Please see appendix 2 for activities to prevent E.coli (urine and blood culture).

1.25 The NHS Long Term Plan supports a 50% reduction in Gram-negative bloodstream infections (GNBSIs) by 2024/25. The ambition commenced in 2017 with an initial drive to reduce *E.coli* BSI by 10% by Q4, 2017/18.

1.26 The pandemic placed a strain on teams across all specialties, and for the IPC this generated the need to stand up the on-call function in the nurse team to match the increased activity in all other wards and departments.

1.27 As a result, valuable staffing resource were directed towards tangible need. The caveat remained that should a significant change occur, the IPCT would further review workstreams/processes, implementing all new approaches after agreement with the DIPC/Board.

1.28 Counts of *Pseudomonas aeruginosa* and *Klebsiella* spp. BSI are lower comparatively.

***Clostridioides difficile* (*C. difficile*/*CDI*)**

1.29 Under the NHS Standard Contract 2021/22, Trusts were required to minimise rates of *Clostridioides difficile*. If a Trust had more than ten cases in the 2019 calendar year, the threshold was set as one less than that count. The Trust reported 56 cases in total, 19 for the Acute and 37 on behalf of the community. This is an increase on previous year's numbers where we reported 38 in total (14 Acute/ 24 Community). Hospital onset, healthcare associated (counts towards Trust objectives)- specimen date is >3days after the current admission date (where day of admission is Day 1).

1.30 We had a threshold set of 9 cases of C. diff toxin associated with the acute sector. We recorded 19 cases across the year, 5 more than the prior year. The number of cases arising in the community were also higher than the previous year (37 compared to 24). We understand that many health economies have seen a higher numerical count of C. diff in 2022/23 than over recent years. The reasons for this are not well understood.
All cases of C Diff toxin are thoroughly investigated.

Please see appendix 1 for MKUH 2022-23 cases.

Orthopaedic Surgical Site Infection

1.31 It is a mandatory requirement to conduct some surveillance of orthopaedic surgical site infections (SSI), using the UK HSA Surgical Site Infection Surveillance Service (SSISS). The data set collected is submitted to SSISS for analysis and reporting. This system is controlled and validated to allow for comparison between centres within England.

1.32 The mandatory requirement is to report one fiscal quarter of orthopaedic surveillance from the following categories:

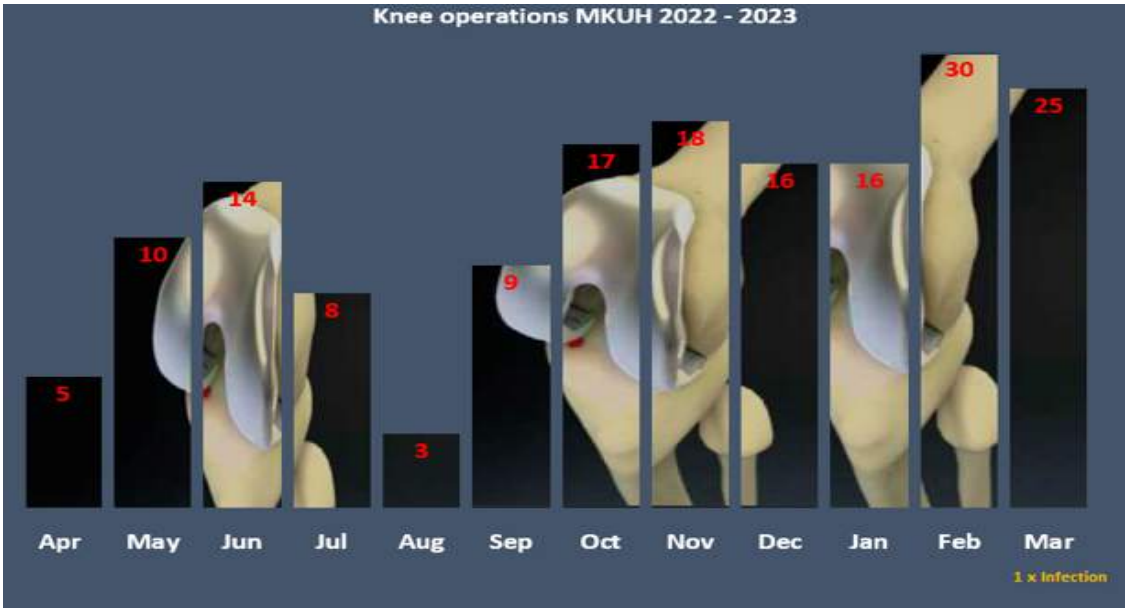
- Reduction of long bone fracture
- Repair of neck of femur
- Hip replacement.
- Knee replacement

MKUH undertakes surveillance of hip and knee replacement continuously Graph showing hip operations for the reporting period.

The Trust is aware that we have negative outlier status for revision procedures, at both 5 and 10 years, following primary hip replacement. Globally, infection is a major driver of the need for early revision. In this context, low rates of surgical site infection across 2022/23 are reassuring.

Hip operations in the reporting period = 164 with zero infection.

Knee operations in the reporting timeframe = 171, with one infection (0.5%)

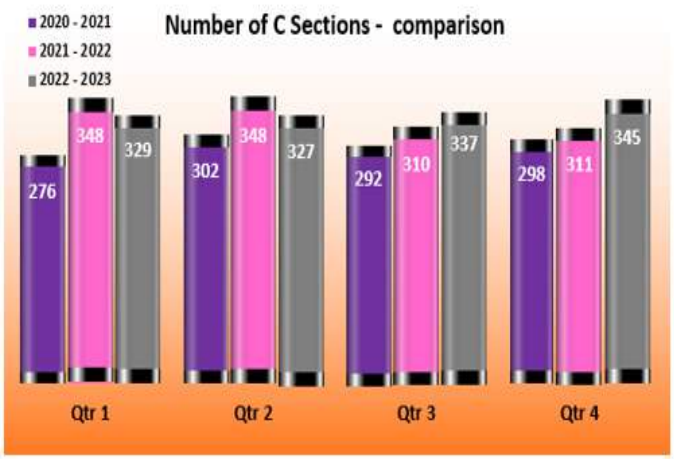


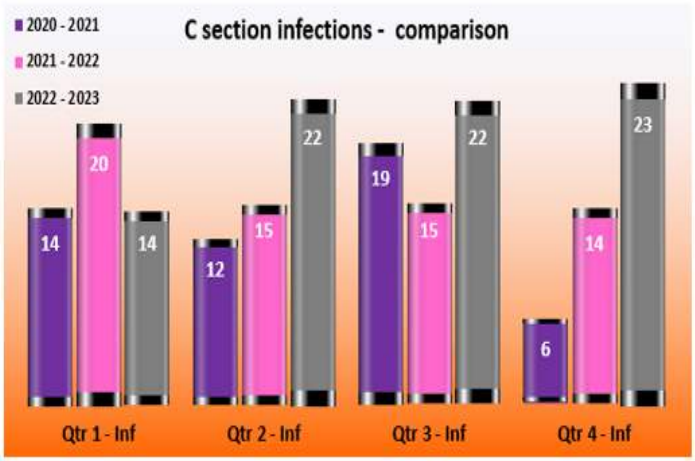
1.33. Continuous SSI surveillance facilitates an accurate picture, and more importantly, local trend analysis from which to draw comparison. Clinicians have engaged well in receiving surveillance feedback, which enables them to make informed changes to practice within the collectively shared desire to lower rates of infection.

Monitoring of Caesarean Section delivery

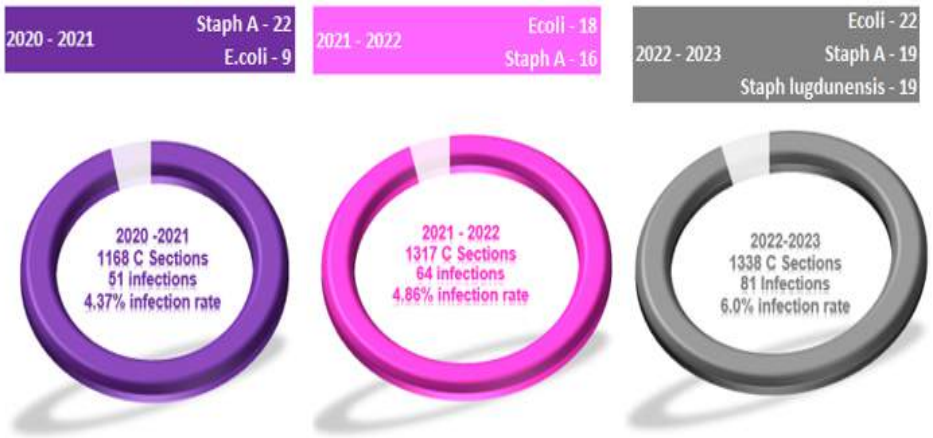
1.34 Surveillance is undertaken at a local level with feedback from the IPCT, cascaded through the governance leads to the obstetric teams.

Comparisons since 2020-2021





Most prevalent micro organisms



Carbapenemase Producing *Enterobacteriaceae* (CPE) surveillance.

1.35 Early identification of patients colonised or infected with CPE is key to control. National guidance for the screening of patients with risk factors for CPE carriage should be carried out on admission. The MKUH continues to move towards compliance, recognising there are still improvements to be made. An audit to test staff adherence to policy is expected in summer 2023.

Vascular device associated bacteraemia.

Targeted work where vascular device could not be ruled out has as being associated with bacteraemia has resulted in improved compliance with the monitoring of visual inspection for the presence of phlebitis (VIP) around cannula site insertion being reported daily on the clinical huddle. Work in 2023/24 will focus on improving both patient and staff education opportunities.

Hand Hygiene Audit

1.36 During a year of unparalleled workload and scrutiny on practice, hand hygiene has remained our highest priority.

1.37 The auditing of Hand hygiene continues with both overt and covert surveillance using software application. Realtime feedback to areas and individuals is essential to drive improvements in compliance.

2.0 Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

This criterion links with Outcome 10, Regulation 15, safety, and suitability of premises contained in CQC guidance about compliance.

Domestic Services

2.1 All cleaning services continue to be managed in-house. The domestic team continually strive to maintain and deliver a quality Domestic Service to the Trust.

2.2 The Domestic Services Department continues to work closely with Matrons, Ward and Department staff maintaining regular daily contact in support of collaborative working. A structured plan of visits has been implemented with each ward having a dedicated point of contact at Supervisory and Management level.

2.3 Alongside the revised Cleaning Standards coming into play, a new audit system named Synbiotix has been introduced from April 2020. It is a web-based Audit System, used with iPads, which provides opportunities to directly review the cleaning scores for all areas

providing a more robust, efficient, and informative service. Cleaning scores are now exhibited on the wards using a star rating system.

2.4 The Symbiotix programme is now being successfully utilised and significant amounts of data relating to current resources and the recommended minimum frequency of clean requirements have been recorded. There is still some functionality to be honed.

2.5 To meet the environmental cleaning demands during the Covid-19 pandemic, the Domestic teams increased resources to meet the challenging demand. This is felt to have been beneficial in improving patient flow in key areas such as the Assessment areas and Emergency Department.

2.6 Areas of domestic cleaning failure are recorded on a rectification sheet, which is used to action and follow up.

2.7 Collated results of monitoring are reviewed, and the results escalated as appropriate. Action plans are implemented for any wards or departments failing to reach the required standards, as directed by the National Guidance.

2.8 The Specialist Deep Cleaning Team are available 24 hours/ day, seven days per week. The site management team liaise with these staff, and this continues to be a positive example of collaborative working.

2.9 There continues to be a swift 'turn-around' time for the terminal cleaning of single rooms, bed spaces or bays that have been vacated by infected patients. The number of cleans required has increased over the last year.

2.10 The IPCT, with the Domestic Services work together to produce a programme of cleaning for the coming year.

2.11 The Associate Chief Nurses/Midwives, Senior Nurses and Matrons have responsibility for ensuring that clinical care is provided in a clinically hygienic environment. Working closely with all other relevant staff to ensure standards are maintained.

2.12 Access to the clinical areas is made during the daytime in inpatient areas and in the evening, or at night in outpatient or day case departments - this minimises disruption to patients and clinical staff.

2.13 The adjustment of the times when outpatient or day case departments are cleaned provides a more robust infrastructure to support ad-hoc specialist/outbreak cleaning requirements during late afternoon/evenings, particularly when we have outbreak situations, e.g., Norovirus.

2.14 The cleaning of patient equipment is undertaken by nursing/ midwifery/ AHP staff before and/or between individual patient use.

2.15 Domestic supervisors continue to review the working practices of the domestic staff at ward level to ensure that a methodical approach to their daily work is being applied consistently.

2.16 Where departments employ housekeepers, they are provided with specific training to include the cleaning and decontamination of patient equipment, deep cleaning, etc.

2.17 Domestic Services continue to update and define the local induction pack for new starters to ensure they are competent in their role when cleaning in both clinical and non-clinical areas.

2.18 A cleaning schedules are issued to all domestic service staff based on the national NHS Cleaning Manual. This links into core competencies for staff and the Knowledge and Skills Framework.

2.19 The annual PDR process for domestic staff also provides an opportunity to undertake an annual competency check to ensure staff are aware of the correct cleaning processes and where appropriate, remedial action and refresher training can be undertaken. Opportunities for personal development are encouraged.

2.20 A monthly Domestic Steering Group is chaired by the Associate Chief Nurse for IPC in support of shared working practices.

2.21 PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

The Hospital Sterilisation and Decontamination Unit

2.22 The Trust has effective arrangements for the appropriate decontamination of instruments and other equipment. The Trust is fully compliant with HBN/13, operates a quality management system in accordance with ISO 13485:2016 and has registration under the UK Medical Devices Regulation 2020.

A sterile health care product is one that is free of viable microorganisms. International Standards (IS) that specify requirements for validation and routine control of sterilisation processes require, when it is necessary to supply a sterile health care product, and that adventitious microbiological contamination of that health care product prior to sterilisation be minimised.

The MKUH unit celebrated a number of successes across the year, in accreditation with the ISO 13485, this covers all aspects of reprocessing and both the Hospital Sterile Decontamination Unit (HSDU) and the decontamination unit in the MKUH endoscopy department passed.
We also comply to the decontamination requirements in the JAG accreditation – JAG stands for joint advisory group who monitor standards in Endoscopy services.
Offsite contingency has not been put into action for 12 months, which demonstrates the value of the planned maintenance programme now in place.

Linen Decontamination Unit (Decontamination of Healthcare Textiles)
The MKUH commissions an external provider for the purpose of linen decontamination/ supply of fresh linen and has assurances that the supplier meets the standard requirement as detailed in 2.23.

2.23 The Health Act Code of Practice recommends that healthcare organisations comply with guidance that outlines the requirement for laundering establishments, who provide linen to the Healthcare and Social Care sectors, to work to one of two standard requirements. These are Essential Quality Requirement (EQR) and Best Practice (BP). EQR is the minimum working standard required. All establishments must also have plans in place to attain the BP standard and this will undoubtedly be the desired requirement for Acute Trusts and other healthcare providers when purchasing new laundering services in the future.

Water Safety

2.24 *Legionella* spp. and *Pseudomonas aeruginosa* are two bacteria that are capable of living in hospital water systems and have the potential to cause clinically significant infections in patients.

2.25 The Water Safety Group (WSG) meet regularly to discuss matters related principally to *Legionella* spp. and *Pseudomonas aeruginosa*.

2.26 Membership of this group includes the Estates department, infection prevention and control, accredited microbiological sampling laboratory services under the guidance of the Evolution Group.

2.27 Microbiological control of *Legionella* is achieved by:

- Temperature: The Trust employs temperature control as the primary method of *Legionella* control within the domestic water systems (as far as is reasonably practicable). This is achieved by maintaining temperatures of:
    - Cold water at temperatures of < 20°C
    - Stored hot water at >60°C (where exceeding 15 litres storage)
- Avoidance of Stagnation: experience has shown that avoiding stagnation is highly important in keeping bacterial counts within acceptable limits. This is achieved by the following:

- Removing any ‘blind ends’ on distribution pipework as far as is practicable.
- Ensure all ‘Dead-Legs’ (e.g., low use taps) are either flushed or removed including any associated pipework.
- Minimising stored water
- Designing and installing new or modified systems so that the risk of stagnation is minimised.

- Maintain cleanliness.
- Pipework, distribution, storage, plant, and outlets shall be maintained in a clean condition at all times as far as is reasonably practicable to avoid providing nutrients to bacteria.

2.28 Where contamination has been detected in water outlets, sometimes associated with stagnation of water due to areas of the hospital being out of use during capital project work. Procedures have been put in place via the trust WSG to include formal presentation of capital works to ensure control measures are mentioned are maintained during and upon completion of any project.

2.29 Testing for *Pseudomonas aeruginosa* in augmented care areas (i.e., neonatal unit and intensive care unit) is also performed. Any remedial action required is promptly taken by the estates department to reduce the risk to patients and this is discussed at the WSG. Areas with *P. aeruginosa* counts are inspected, and the remedial action may include removing flexible pipework, reducing unnecessary pipework, and decontaminating outlets. The cleaning by the domestic teams of hand wash basins is subject to regular audit, as is the compliance with flushing regimes, dictated by the national policy.

NHS Premises Assurance Model (NHS PAM)

2.30 The NHS PAM is a management tool that provides NHS organisations with a way of assessing how safely and efficiently they run their estate and facilities services. It is a basis for:

- Allowing NHS healthcare providers to assure Boards, patients, commissioners and regulators on the safety and suitability of estates and facilities where NHS healthcare is provided.
- Providing a nationally consistent approach to evaluating NHS estates and facilities performance against a common set of questions and metrics.
- Prioritising investment decisions to raise standards in the most advantageous way.

Under the terms of the NHS contract (Service Conditions 17.9) NHS PAM became mandatory for all NHS trusts to complete annually from 2020/21.

2.31 The trust is expected to maintain the “Good” rating for the PAM assessment for the coming year, subject to release of any further guidance. Areas of improvement are reported through the Estates and Facilities Governance Groups.

3.0 Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.

3.1 AMS optimises the treatment of infection and minimises the collateral damage associated with antimicrobial use such as the emergence of resistant organisms and CDI. It is recognised as one of the key components of IPC. AMS has remained a national priority throughout the Covid-19 pandemic and national targets set within the NHS contract continue to aim to drive down antimicrobial usage.

3.2 Stewardship activities were scaled back during the pandemic, but there has been a gradual increase across the reporting period.

- Weekly Stewardship ward rounds with a multi-disciplinary team (MDT) including microbiologist, clinicians, leads antimicrobial pharmacist and the patient where practicable.
- Virtual review of antimicrobial use is undertaken to identify those patients on antimicrobials.
- Provision of educational sessions to junior medical staff and pharmacists.
- Antimicrobial usage continues to fluctuate and can be associated with seasonal activity i.e., respiratory viruses and notably the need to treat Group A Streptococcal infections.
- Microguide app is used to provide a platform for trust antimicrobial and surgical guidelines.
- The Outpatient Parenteral Antimicrobial Therapy Service continued to expand and develop.
  The Antimicrobial Stewardship Group (ASG), which oversees the development and implementation of the Trust annual AMS programme of work met over the year and was quorate on each occasion.
  Multidisciplinary team review of trust *Clostridioides difficile* infections occurs in real time.

3.3 A number of key challenges, which result in ‘partial compliance’ with criterion 3 namely:

- Availability of reports to provide data measuring adherence to key performance indicators for antimicrobial stewardship in the Trust.
- Resources to provide detailed data analysis of infection management, antimicrobial prescribing, and breakdown of consumption figures.

- Resources to extend our stewardship activities to provide more frequent stewardship rounds with clinicians and clinical pharmacists and for greater involvement for nurses/ midwives.
- Resource to provide timely review the complete package of trust antimicrobial guidelines.
-

4.0 Criterion 4: Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion. This criterion links with Outcome 6, Regulation 14 co-operating with other providers contained in CQC guidance about compliance.

4.1 The IPCT works with the bed managers/site team in planning patient admissions, transfers, discharges and movements between departments and other healthcare facilities.

4.2 Local policies require information on potential infection hazards to be forwarded to other institutions before patients are transferred out of the Trust. The IPCT supports the discharge planning and or repatriation of patients from other healthcare providers.

4.3 The use of the electronic patient record has also played a key role in ensuring that accurate information is available to those engaged in patient care.

4.4 Significant improvements will be introduced, including the ability to confirm bay/ward closures because of infections, enhanced reporting according to infection, type of patients/areas affected and number and location of contacts with the introduction of the capacity management software (CAPMAN).

4.5 Some of the key workflows i.e., clinical management of MSSA bacteraemia have seen improvement through automation e.g., eCARE.

4.6 During the year, proactive work has continued with GP Practices, notably around support of screening for TB, contact tracing and patient management.

4.7 The team has continued to review toxigenic cases of *Clostridioides difficile* arising in the community in people who have had no hospital admissions in the four weeks prior to specimen. The process for review involves seeking information from the person's medical practice regarding symptom onset, recent antimicrobial treatment, and risk factors. The aim of the reviews has been to generate learning across the Bedford, Luton, and Milton Keynes (BLMK) healthcare providers.

4.8 IPC and TB Team members have represented the service at a number of regional events.

4.9 Progress regarding work to reduce the number of Gram-negative bloodstream infections was not significantly advanced, largely due to the Pandemic, but remains an expectation for the year ahead with the opportunity for greater collaborative working.

5.0 Criterion 5: Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

5.1 The Trust is able to demonstrate that responsibility for infection prevention and control is effectively devolved to all professional groups by means of inclusion in all job descriptions and mandatory inclusion in appraisal documentation including for medical staff.

5.2 Compliance with mandatory training and completion of appraisal are reported monthly. This is monitored at executive level.

5.3 The Trust is reviewing screening against national guidance.

5.4 Point prevalence audits of compliance with antibiotic prescribing are undertaken and reported regularly to the AMS Group.

5.5 On introduction of the capacity management software the Trust will better monitor compliance with the appropriate isolation of patients, including time to isolation.

6.0 Criterion 6: All care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

6.1 Criterion 6 refers to the training and education of staff, which include Trust staff, bank nursing staff, contractors, and volunteers. Induction and mandatory update training is provided for all staff. Standard Infection Control Precautions and isolation precaution training is provided for the clinical and support staff, and the responsibility for Infection Prevention and Control is described within job descriptions in accordance with the Hygiene Code.

6.2 Part of the recognised role of the IPCT is training and education. This takes the form of face-to-face sessions. Mandatory education is delivered via on-line packages.

6.3 The Trust works across the health economy on Infection Prevention and Control measures, including working with the Health Protection Unit, UK HSA, the integrated care services, and boards (ICS and ICB) and the Regional Epidemiology Unit.

6.4 Line managers are notified of non-attenders at induction and mandatory training. It is the responsibility of the line manager to ensure that non-attenders are followed up and complete their training.

6.5 Fit testing for respiratory protective equipment is undertaken for all staff in high-risk areas. The responsibility is moving from the R&D team (delivered by them during Pandemic months) to OHWB.

7.0 Criterion 7: Provide or secure adequate isolation facilities.

The IPCT take every opportunity to promote compliance within plans for new builds and refurbishment/renovation to maximise the ability to control outbreaks and that these should include bays with doors.

7.1 The Trust recognises the need to maintain and expand facilities for patient isolation for infectious purposes, while recognising the need to provide single room facilities for patients requiring privacy for other reasons. Improvement is required for a number of single rooms (as most single rooms do not have *en suite* toilet and shower facilities and are very small). The low number of negative pressure rooms is recognised as a risk for the Trust, impacting on compliance with this criterion, as does the paucity of areas for donning and doffing of personal protective equipment (PPE).

7.2 To assist staff, the Trust has a Source Isolation policy and organism specific policies detailing the need for isolation and the IPCT advise on prioritisation of patients requiring single rooms.

7.3 To overcome the challenge of the low proportion of single rooms to total beds, cohorting patients with the same infection is used where necessary, including in the event of a cluster or outbreak of a specific organism.

7.4 Covid-19 has placed additional strain on isolation facilities of the hospital. As well as the cohorting patients, mitigating factors include admission screening of individuals and a low threshold for rapid testing of patients who develop features that could indicate Covid-19 infection (e.g., fever, cough) were implemented.

8.0 Criteria 8: Secure adequate access to laboratory support as appropriate

8.1 The laboratory services are located within the main MKUH premises. The microbiology laboratory is working towards UKAS re-accreditation which requires providing appropriate protocols and standard operating procedures (SOP).

8.2 There is provision of seven-day laboratory working and 24-hour access to microbiology advice, including a 24-hour Point-Of-Care Testing facilities in ED and paediatrics for rapid PCR testing when required (e.g., Covid-19, respiratory viruses and Group A Strep).

8.3 There is a close working relationship with the IPCT; Microbiology Consultants, laboratory staff and pharmacy who hold weekly meetings, chaired by the associate chief nurse for IPC, to address ongoing and new issues.

9.0 Criteria 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

9.1 A comprehensive infection control document section is available, via the Trust's intranet page (including posters, video clips etc.).

9.2 The National Infection Control Manual has been adopted by the Trust supporting staff to identify clinical situations where isolation precautions may be required before any infection risk has been confirmed (e.g. patients with pyrexia of unknown origin with foreign travel history).

9.3 The IPCT is responsible for the maintenance and updating of the infection control policies, procedures, and guidance documents.

9.4 The antimicrobial prescribing policy is the joint responsibility of the consultant microbiologist and antibiotic pharmacist and is approved by the Antimicrobial Stewardship Group.

9.5 The decontamination policies and procedures are the responsibility of the decontamination lead (Marea Lawford).

9.6 The auditing of compliance with key policies has reduced across the pandemic period, which impacts fulfilling this criterion.

9.7 The IPCT collaborates with BLMK in support of a standardised approach across the Integrated care systems (ICS).

Criteria 10: Ensure, so far as reasonably practicable, that care workers are free of and protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

10.1 Occupational Health and Wellbeing undertake core work including-vaccination and blood screening where indicated to reduce the risk of infection in staff.

10.2 The team have supported an increased screening for TB.

10.3 The team are active participants in the MKUH Green Plan- supporting appropriate use of disposable gloves, reducing avoidable waste, promoting skin health and efficient use of the public purse.

10.4 The Covid-19 advice for staff proved time consuming as the number of calls by staff to the department, increased significantly due to the Omicron variant surge.
Occupational staff support staff identified with a positive Covid-19 PCR with regards to their likely infectivity, and safe return to the workplace.

Key areas of Focus for 2023/4

- Provide support to clinical teams in and out of the organisation as part of medicines optimisation to reduce the use of proton pump inhibitors (PPI) in people over the age of 65 yrs., known to suffer chronic conditions who may require antibiotics. The aim being to reduce the potential for these patients to develop *Clostridiodes difficile*.
- Accelerate antimicrobial stewardship activities in non-prescribers, clinical and non-clinical staff, patients, and families.
- Collaborate with the healthcare communities to reduce the risk of *E.coli* and other gram-negative bacteraemia.
- Continue to promote knowledge and compliance with hand hygiene practice and all other standard infection control precautions through education and audit activity.
- Promote the use of the National Infection Control manual for England.
- Continued input into new build and or refurbishment projects as required, together with infection prevention and control advice.

Conclusion

Infection prevention and control is the responsibility of all Trust employees and the IPCT do not work in isolation. All successes over the past year have been made possible with the commitment demonstrated by staff within the organisation. Exacting standards of IPC and AMS remain crucial to minimising risks and limit both infection and the emergence and spread of multidrug resistant organisms.

Despite considerable challenges this year, and the successes identified within the report, challenges remain as we move into a post pandemic phase with the expectation that emerging resistance will exert greater pressures on our capacity to treat, isolate and contain infections that pose a threat to public safety.

Preventing infection through basic measures has never been so important and it remains our duty to provide safe, clean care to our local communities.

Financial Implications There are no explicit financial implications within the paper however it is acknowledged that there are both financial and patient experience, plus quality-of-care cost associated with infection attributed to healthcare.

TheMKWay

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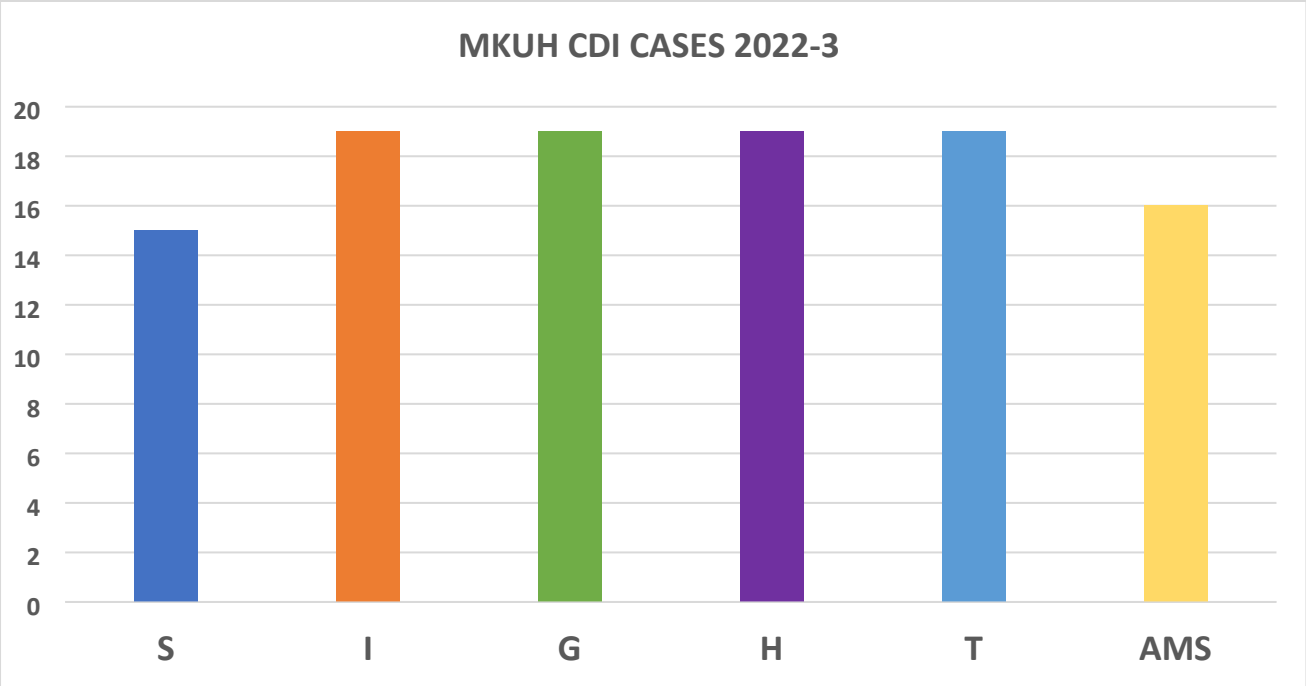
National Infection Prevention and Control Manual NHS England » National infection prevention and control manual (NIPCM) for England

Appendix 1. **C diff.**

MKUH had a threshold set of 9 cases of C. diff toxin associated with the acute sector. We recorded 19 cases across the year, 5 more than the prior year. The number of cases arising in the community were also higher than the previous year (37 compared to 24). We understand that many health economies have seen a higher numerical count of C. diff in 2022/23 than over recent years. The reasons for this are not well understood.

All cases (antigen and toxin) are investigated against six nationally agreed standards (SIGHT-AMS). This evidences individual patient care being met. Where a gap is identified against one or more standard, the case may be regarded as potentially avoidable.



S	Suspect that a case may be infective where there is no clear alternative cause for diarrhoea
I	Isolate the patient and consult with the infection prevention and control (IPC) team while determining the cause of the diarrhoea
G	Gloves and aprons must be used for all contacts with the patient and their environment
H	Hand washing with soap and water should be carried out before and after each contact with the patient and the patient's environment
T	Test the stool using a 2-step testing system, sending a specimen immediately (see Appendix 2 for interpretation of a 2-step testing
AMS	Assess the appropriateness of prescribed antibiotics in relation to avoiding CDI. Over 65 years = 17 of our 19 cases.

In addition to these six standards, we also examine other elements; the use and indication for other medicines known to be associated with C diff, – such as proton pump inhibitors, we further scrutinise environmental cleanliness, that the correct frequency and products are, and have been used for decontamination of near patient equipment, whether any increase in patients/staff reporting unexplained diarrhoea within the same ward/area during the previous month has been adequately investigated, or has the patient has been exposed to another known to have C. diff. Adherence to hand hygiene by all staff, the correct choice, duration of wear and disposal of personal protective equipment (PPE) is an integral part of monitoring.

If we use compliance with hand washing as an example, we review the hand hygiene audit results for the clinical areas in which the patient received care prior to / at the time of the development of diarrhoea. Please see page 32 for update on increasing the opportunities for hand hygiene compliance.

Of the 19 cases:
In 4 cases, teams did not suspect that diarrhoea was infective at the time of the patient's presentation (and immediately manage accordingly) despite there being no clear alternative cause.
In 3 cases, antibiotic prescribing in the run-up to presentation was not appropriate or in line with local guidance. Where deviation has occurred, the rationale for that is made evident and any ensuing remedial action, shared.
All positive samples are typed by the Leeds reference laboratory to allow for prompt recognition of any hypervirulence factors.

Post pandemic, we are beginning to hear that whilst Covid-19 patients are not considered at increased risk of C. diff infection, those already infected with C diff are thought more likely to experience severe outcomes. Three out of our nineteen cases of CDI had suffered Covid-19 but there is no evidence to suggest their experience of CDI was exacerbated as a result.

Next steps (2023/4)
As we recover from the pandemic, the multifaceted nature of CDI and rising numbers of cases drives the necessity of a strong refocus on efforts to improve prevention strategies and to better integrate CDI surveillance across the Bedford, Luton, and Milton Keynes (BLMK) health landscape in order to curtail this public health threat. Lack of judicious testing can result in the incorrect diagnosis of Clostridioides difficile infection (CDI), unnecessary CDI treatment, increased costs, and falsely augmented hospital-acquired infection (HAI) rates.

Our combined efforts will see strengthened governance with regard to whole health economy team involvement, reviewed patient information, the consideration of a guide to suspending, where appropriate, the use of proton pump inhibitors (PPI) for patients requiring hospital admission, over the age of 65 yrs. with co-morbidities and requiring antibiotics.

If able to implement this at the point of medication reconciliation, the risk of CDI may be lessened. GP`s as stakeholders are key to influencing the safe reduction of prescription of long-term PPI in their patient cohort and for those patients who, on scrutinising health records are found to have repeat prescriptions of antibiotics known to increase risk.

Wherever health care is delivered, antimicrobial stewardship, the correct choice and disposal of personal protective equipment, hand hygiene with soap and water (staff, patients, and visitors) early accurate assessment of appropriate need to sample stool, with timely lab results and action, the safe isolation of the symptomatic patient, the maintenance and evidence of a clean environment all play vital roles in this reductive plan. A thorough review of the microbiology laboratory processes has included differentiation of liquid versus formed stool, to support appropriate testing. All samples are tested within a 24-hour period from receipt.

Hand Hygiene: We have accelerated our campaign to optimise hand hygiene for all staff, patients, and visitors. Continuing the work started in November 2022, with our soap, sanitiser, and hand lotion supplier SC Johnson, we have completed a trust wide review of the products being used, their location and the condition of dispensers.

We checked that there is a dispenser for soap above each clinical sink, that sanitiser is available at the point of care plus at entrances and exit points and that staff have access to moisturising hand cream. All staff have the opportunity to carry individual hand sanitiser.

Driving compliance with a 6-stage plan

To make sure all our teams are practising the best possible hand hygiene, SC Johnson works in partnership with us to re-energise our compliance plan, comprising of:

1. A survey. review products – location and condition – and accompanying signage to assess current hand hygiene infrastructure.
2. benchmark and measure current hand hygiene compliance and skin health to create a baseline for comparison.
3. Refurbishing. update products and signage to improve hand hygiene infrastructure based on data collected.
4. Training, to help reinforce product use guidance and technique to deliver best practice.
5. supported by provision of continuous learning and feedback to promote high standards.
6. Evaluation. re-measure hand hygiene compliance and skin condition against the benchmark to establish the outcome and next steps.

This programme is designed to provide products that are trusted to work and have been independently tested to high standards and tailored to the requirements of our hospital, whether that is our emergency assessment areas, the patient wards and departments or those facilities open to our public.

Our progress against this will be shared at the Infection Prevention and Control Committees throughout the year, both internal and external.

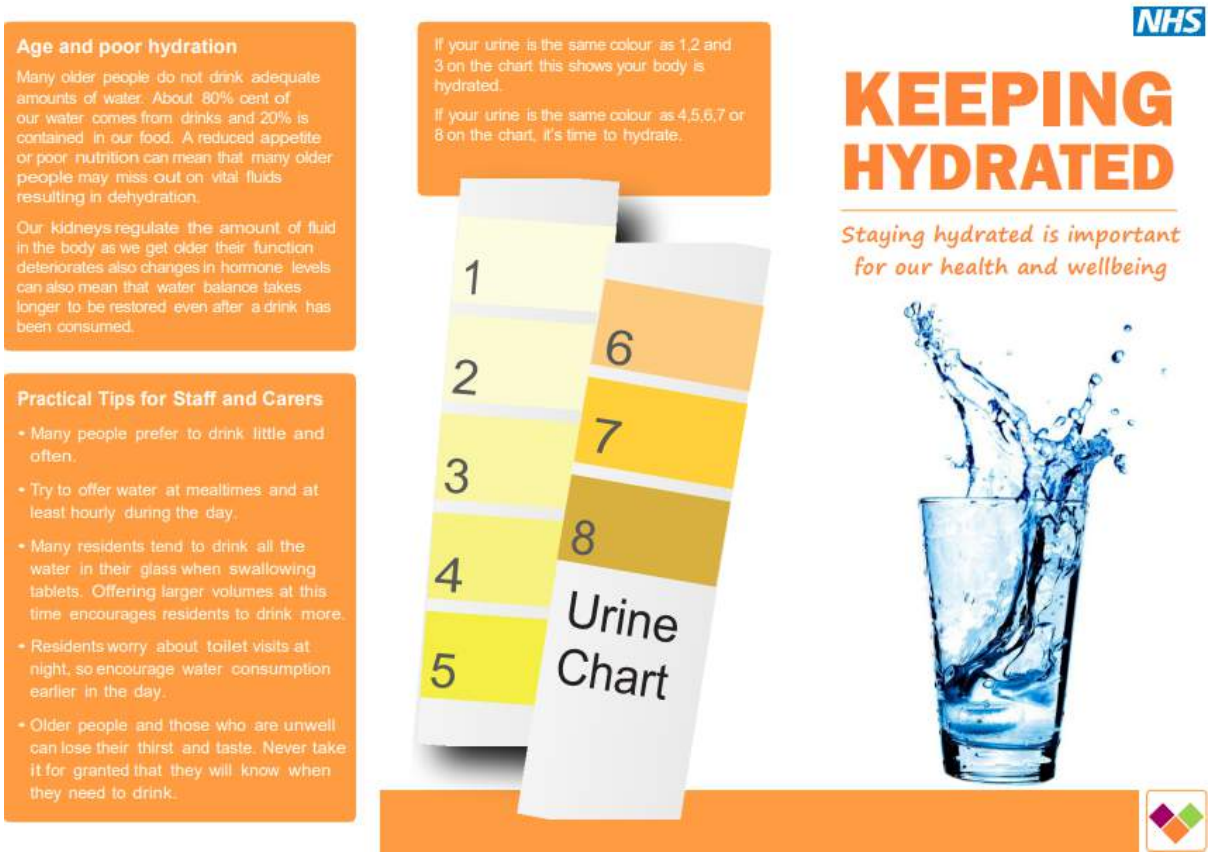
Appendix 2.

Reinvesting in hydration, continence, catheters, and AMS to improve patient experience, outcome and reduce E. coli infection.

Angela Legate ASCN IPC

This is not an exhaustive list but one that can be used to generate multidisciplinary thinking/planning.

Hydration – review and amend of our electronic audit questions – core element in communication strategies to drive improvement (staff, patients and public)



Continence: MKUH benefits from joint working with community continence specialists and re-launch of education programme developed by Liz Winter – Divisional Chief Nurse for

medicine/emergency care. Support confirmed through clinical review group and urology nurse specialists.

Guidance on continence care is directed towards adult care. * re launch of continence products is under review with roll out expected across the organisation in the next few weeks.
Bladder and bowel dysfunction are embarrassing and debilitating problems which can affect up to one third of the population. At best, it might cause minor irritation but often causes social isolation, shame, and depression.
70% of bladder problems have been found to be curable or significantly improved, with relevant guidance, and it should be remembered that incontinence, frequency, urgency, constipation, etc. are symptoms of underlying conditions which need to be diagnosed and treated appropriately, following adequate assessment using care pathways and relevant assessment tools.

Reminder of the basic principles of good catheter care

Catheterisation should only be used as a last resort in the management of incontinence. An indwelling catheter may be inserted into the bladder via the urethra or a supra pubic cystostomy. Catheterisation is associated with a number of potential complications, which in the case of supra pubic catheterisation includes bowel perforation. It should also be remembered that of the 1-4% of patients develop bacteraemia from a catheter acquired urinary tract infection (CAUTI) which can be life threatening. There are, however, some patients for whom long-term catheterisation is the most appropriate form of care.

The aims of catheter management are:

1. To relieve and manage urinary dysfunction.
2. To recognise and minimise risk of secondary complications.
3. To promote patient dignity and comfort and to assist patients reach their own potential in terms of self-care and independence.
4. To provide a cost-effective service

Before carrying out long-term catheterisation the nurse should:

- carry out a holistic assessment of the patient.
- discuss with GP.
- gain informed consent. This should be a joint decision with the patient, health professional and if appropriate with the carer/relative (see local policy on consent)
- select the appropriate type and size of catheter.
- have the appropriate knowledge and skills to carry out the procedure.
- discuss sexuality as appropriate to the individual patient.

- give verbal and written information about the catheter and its care.
- provide appropriate leg bags and night bags.
- provide the appropriate suspension system.
- plan individualised care.

Catheterisation is an aseptic procedure. The genitalia or meatus should be cleansed prior to insertion with sterile or normal saline. Further information can be obtained from the Infection Prevention and Control Manual on the MKUH intranet.

The healthcare worker responsible for the catheterisation will carry out the relevant documentation. This will include:

- patient consent to be gained and documented.
- the date and time of the procedure.
- site of catheter: urethral or supra pubic.
- the type, size, and batch number of the catheter.
- the residual volume of urine drained if first time catheterisation.
- the date the catheter is due to be changed.
- complete care plan.

Contact Details

Clinical staff can call on ****** to give support, help or advise in the care of any particular patient or to assist in decision making regarding urinalysis.

*contact details/available hours to be confirmed

Catheter management, problem solving

There are three main categories of complications, which can arise during long-term catheterisation.

1. Tissue damage and inflammation
2. Urinary tract infection
3. Catheter encrustation leading to blockage

Tissue damage

Urinary tract infection

Complications and problem solving

Urinary tract infection

- During catheterisation (extraluminal)
- Following migration within the catheter lumen from the collection bag (intraluminal)
- Via the mucus film adherent to the external catheter surface (extraluminal late)

Reducing the Risk of Infection

- Use closed drainage system.
- Normal daily hygiene to meatal area. The area should be dried well. Alternatively, a daily bath or shower would be sufficient.
- Care staff should wash hands and wear clean, non-sterile gloves before emptying or changing catheter leg bags. Hands should be decontaminated after removing gloves.
- A mixed fluid intake of at least 2 litres or 3 pints a day.

To dip or not to dip? UKHSA (PHE) guidelines, revised in 2018 to state that urine dipsticks tests should not be used as a diagnostic aid in any patient over the age of 65 years. The high prevalence of asymptomatic bacteriuria in the elderly population is widely acknowledged but maintaining “not dipping” remains a challenge, particularly in the acute assessment areas and the ICU.

Revisiting UTI – adults, as per NICE guidance

Urinary tract infection (lower) - women | Health topics A to Z | CKS | NICE

Suspect urinary tract infection (UTI) in a woman presenting with typical features of UTI (in the absence of vaginal discharge or irritation) such as:

Dysuria — discomfort, pain, burning, tingling, or stinging associated with urination.
Frequency — passing urine more often than usual.
Urgency — a strong desire to empty the bladder, which may lead to urinary incontinence.
Changes in urine appearance or consistency:
Urine may appear cloudy to the naked eye or change colour or odour.
Haematuria may present as red/brown discolouration of urine or as frank blood.
Nocturia — passing urine more often than usual at night.
Suprapubic discomfort/tenderness.
Typical features may be absent, in particular in elderly women with underlying cognitive impairment — consider UTI if the woman presents with:

Generalized non-specific clinical features such as delirium, lethargy, reduced ability to carry out activities of daily living and anorexia.
Alternative sources of infection and causes of delirium other than UTI must be excluded before a working diagnosis of UTI is made.
Pyelonephritis should be suspected in people with fever, loin pain or rigors.

Audit staff understanding of risk – see below as an example from NICE when considering associated risk.
Urinary tract infection (lower) - men | Health topics A to Z | CKS | NICE

Strong risk factors for urinary tract infection (UTI) include:
Age over 50 years.
Benign prostatic hypertrophy (BPH) and other causes of urine outflow obstruction (for example, urinary tract stones, urethral stricture) — up to 30% of young men with UTI have anatomical or functional abnormalities of the urinary tract, and this is higher in older men.
Catheterisation — UTI is the most common hospital acquired infection, and the majority of cases result from indwelling catheters.
Previous urinary tract instrumentation or surgery.
Previous UTI — the risk of acquiring another UTI increases with each subsequent infection.

Other risk factors include:
Anal sex.
Diabetes mellitus.
Immunosuppression.
Recent hospitalisation.
Uncircumcised men.
Vaginal sex.

Constipation and UTI

This is the most common cause of faecal incontinence in the elderly and for disabled people. When you become constipated, especially when the faeces become extremely hard or “impacted”, your body tries to soften the stool by adding liquid to it. This can result in a type of diarrhoea, known as “spurious diarrhoea”, which is characteristically orange or light brown in colour.

Faecal incontinence of this type is characterised by prolonged periods of no bowel movement followed by a few days of incontinence. Several factors can contribute to constipation. These include:

● A diet that is low in fibre. Your diet should be rich in fibre, including brown bread, fruit, vegetables and natural bran.
● Low fluid intake. You should maintain a good fluid intake of at least 1½ - 2 litres (Three pints) each 24 hours.
● Poor mobility. Wherever possible, you should take gentle exercise, such as walking.
● Some medicines, for example continual use of painkillers such as codeine phosphate.

ref: www.bladderandbowel.org | Email: help@bladderandbowel.org

Urinary tract infection. UTIs are the most common bacterial infection treated by the NHS, mostly using antibiotics prescribed in primary care. In some cases, antibiotic resistant UTIs are as high as 50%, resulting in longer, more severe infections, requiring multiple antibiotic courses.
Whole health economy buy in to limiting unnecessary use of broad-spectrum antibiotics in patients with unremarkable background could be considered as worthy of exploration as a core target in UTIs antimicrobial stewardship, across 2023/4.

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NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Research & Development

Annual Highlights 2022 - 2023

Welcome

We are delighted to present the 2022-2023 Annual Report on Research and Development (R&D) at Milton Keynes University Hospital NHS Foundation Trust (MKUH).

2022-2023 has been and exceptionally year for Milton Keynes University Hosptial NHS FT Research and Development Department, exceeding previous recruitment achievements with the engagement and collaboration of everyone within the research infrastructure, the Trust, regional and national partners and our stakeholders. With a portfolio of 73 active clinical trials, research team has recruited 7,951 participants, placing our Organisation on the top of the NIHR Research Activity League Table for Medium and Small Acute Trusts (similar size organisations) and over the last couple of years MKUH research publications and presentations from local, national and to international, has significantly increased.

Additionally, MKUH has been actively engaged supporting all aspects of UK Clinical Research Recovery Resilience and Growth programme as set by DHSC and NHSE, ensuring the restoration and delivery of a full portfolio of clinical research, maximising opportunities to rebuild research activities with the main focus of Research Reset. Recovering the UK clinical trial delivery system post-pandemic has been the Research Reset programme's main objective, and underpins the ambitions set out in Saving and improving lives: the future of UK clinical research delivery. Nevertheless, we were proud to have been amongst the highest recruiting hospitals of our size to the RECOVERY trial that identified a number of interventions that saved the lives of COVID-19 patients.

Furthermore, the atmosphere of collaboration and enthusiasm from acute physicians, intensive care consultants such as Dr Richard Stewart (RECOVERY PI) and other colleagues across the Trust involved in research at MKUH continues. We have also seen new areas of research starting at MKUH. As an exemplar, MKUH has been one of the first hospitals in the UK to use the CMR Surgical Robot to assist surgeons in general, urological and gynaecological surgery and this has generated media interest. Research studies to assess the impact of this new technology have started at MKUH led by Professor Barrie Keeler, Consultant Surgeon.

The regular meetings (mainly by MS Teams) of the regional university networking group continue to develop collaborative and innovative projects under the direction of Professor Oliver Pearce alongside his research into the use of drones to deliver samples from hospital to laboratory. MKUH clinicians are also leading or are key collaborators in other areas of research into new technology such as the research by Professor Attila Kardos into the use of medical devices to monitor cardiac patients and the use of artificial intelligence in interpreting cardiac scan data.

Antoanela Colda, Head of Research and Development Department, has continued to lead, develop and motivate the R&D Team who have worked tirelessly throughout the year to support clinicians and ensure that studies were done to the highest standards of good clinical practice. The new Cancer Centre is now fully operational and is a great opportunity for us to expand our cancer

research activities.

We remain very grateful for the support that we receive from the Thames Valley and South Midlands NIHR Clinical Research Network who fund a significant part of our research team. We further thank the Trust and other hospital departments who have been very supportive of R&D activities. Our R&D patient partners have provided important advice from a participant's perspective into R&D activity at MKUH. As we have done in previous years we are presenting our activities as an infographic and we hope that you find it easy to read. If you need more information on any of our studies or about research at MKUH, please don't hesitate to get in touch.

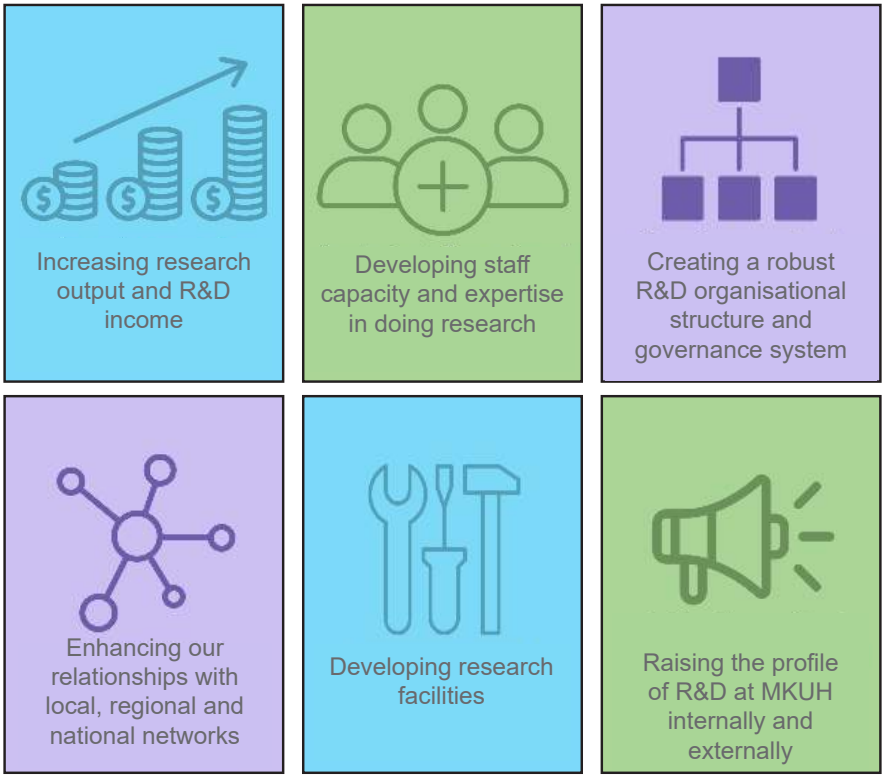
Dr Ian Reckless
Medical Director

Professor Simon Bowman
R&D Director

Research and Development Strategic Aims

April 2021-March 2026

Research and Development is one of the three key aims that make up the Milton Keynes University Hospital Strategy. In order to achieve our ambitious plans over these five years, the R&D Team have six strategic themes. Our strategic aims for R&D are:



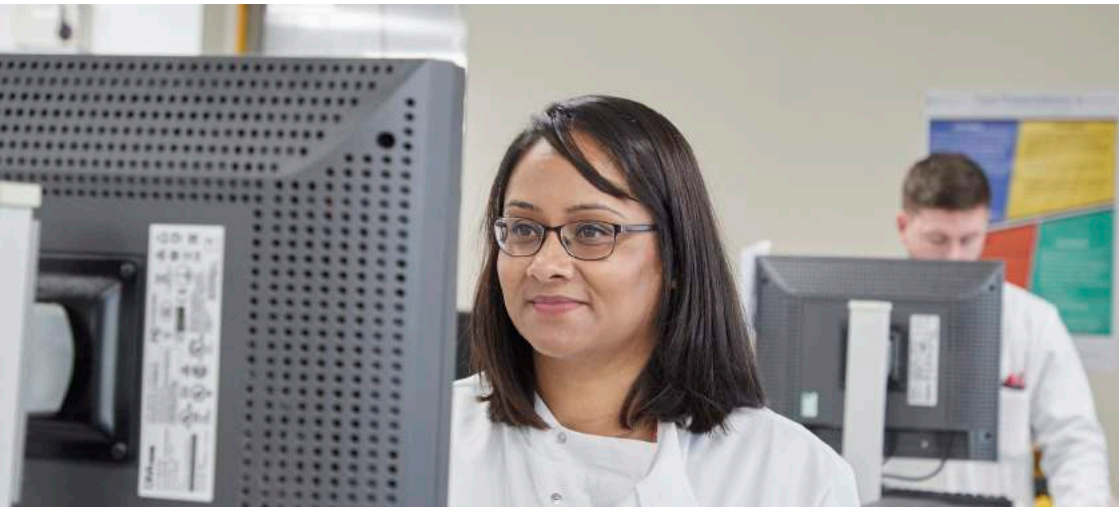
Highlights 2022/2023

At Milton Keynes University Hospital (MKUH) we are committed to delivering high quality care and giving patients equal access to clinical trials, providing them with the latest medical treatments/devices or offering an alternative/additional choice of treatment through research.

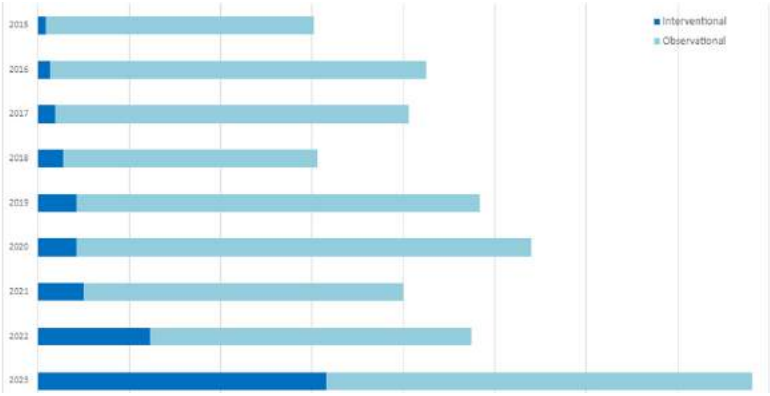
Performance

Clinical speciality recruitment areas

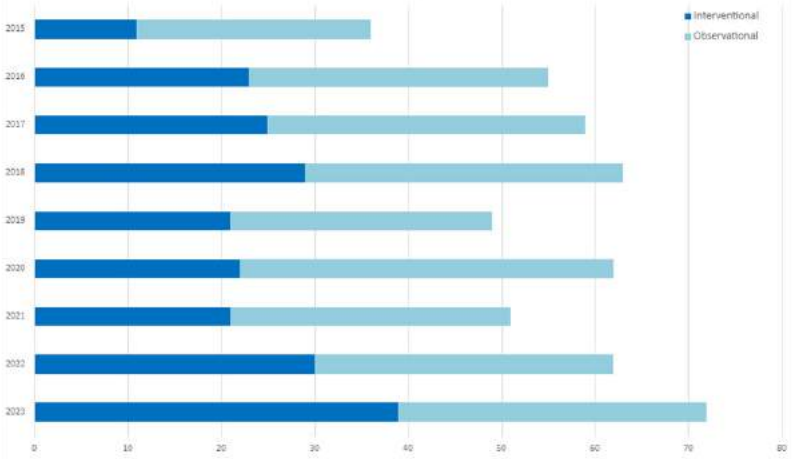
Recruitment in FY23	Recruited	Number of studies
Anaesthesia, Perioperative Medicine and Pain Management	186	3
Cancer	56	8
Cancer (Haematology)	8	2
Cardiovascular Disease	74	5
COVID-19	185	3
Critical Care	153	5
Dermatology	2	1
Diabetes	86	3
Gastroenterology	50	3
Haematology	3	1
Hepatology	46	3
Infection	36	1
Musculoskeletal Disorders	3	1
Ophthalmology	7	2
Paediatric	278	2
Reproductive Health and Childbirth	6232	10
Respiratory Disorders	94	1
Stroke	22	5
Surgery	62	2
Trauma and Emergency Care	368	12
Grand Total	**7951**	**73**



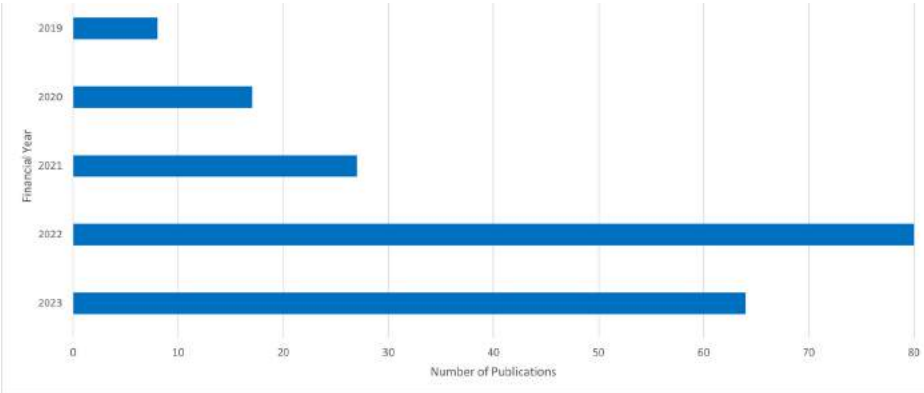
Total study recruitment per financial year



Number of successfully recruiting studies per financial year



Publication count per financial year



Studies

MKUH are hosting, participating and supporting trials in a range of specialities. These include commercial, non-commercial and sponsored studies helping to increase research activity, increasing and improving opportunities for participation.

Speciality areas include:

Awards and Achievements

We were delighted to congratulate our R&D staff receiving awards at the Thames Valley and South Midlands NIHR Clinical Research Network (CRN) Awards in 2022 for their outstanding contributions to research delivery.

MKUH received nominations for the following categories:

- **All-round High Performing Team** MKUH R&D team
- **Outstanding member of support staff -** Deborah Jewel (winner) and Felicity Williams (shortlisted
- **Outstanding PI** - Dr. Divyansh Gulati
- **Outstanding member of support staff** - Jeannette Smith.

Raising the profile of R&D

The team have continued to work hard to raise the profile of research in the Trust and wider community, supporting and engaging with:

- local media: highlighting patients and staff stories, patients and public engagement sessions, radio interviews.
- events: virtual school careers events, international clinical trials day
- External collaborations with local, national and international universities and partners
- Trust level: launching Chief Nurse Research Fellows Programme, active participation to Patient and Family Experience Board, leading Underserved communities forum

Patient Satisfaction

Each year the Thames Valley and South Midlands Clinical Research Network collate all the participant feedback received to extract learning. For 22/23 the key findings were:

- 91.6% of participants said the information they received prepared them before taking part
- 67.8% of participants said they had been kept updated about the research
- 69.5% of participants said they knew how they would receive the results of the research
- 85.6% of participants said they knew how to contact someone from the research team if they had any questions or concerns
- 90.8% of participants said researchers valued their taking part in the research
- 94.6% of participants said research staff always treated them with courtesy and respect
- 90.2% of participants said they would consider taking part in research again
- Staff attitudes, effective study administration and helping others were the most common topics participants felt positive about
- Effective study administration, study methodology and receiving results were the most common topics participants felt would have made their experience better.

The most commonly mentioned topic in freehand comments was relating to staff attitudes such as:

- “All staff were very professional, courteous, friendly and highly trained. I felt very comfortable asking any questions”

- “My research experience has been excellent. Everyone have been so lovely, and friendly”

Get involved!

Want to learn more about research at MKUH?
Are you interested in getting involved?
Contact the team today: 01908 995 137

Meeting title	**Workforce Board**	**Date: -**
Report title:	**Guardian of Safe Working Hours Annual Report (2022 - 2023)**	**Agenda item:**
Lead director **Report author** **Sponsor(s)**	**Name:** Dr Ian Reckless **Name:** Dr Janet Costa **Name:**	**Title:** Medical Director **Title:** GOSWH **Title:**
FOI status:		

Report summary				
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	This report is supplied to board for information only to demonstrate the compliance with current terms and conditions of medical staff in training.			

Strategic objectives links	• Deliver key performance targets. • Develop a robust and sustainable future. • Become well-governed and financially viable. • Improve workforce effectiveness. • Develop as a good corporate citizen.
Board Assurance Framework links	
CQC regulations	• Regulation 17: Good Governance • Regulation 18: Staffing
Identified risks and risk management actions	
Resource implications	Compliance with the employer conditions set out in the *Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016*
Legal implications including equality and diversity assessment	**N/A**

Report history	
Next steps	Report for information only
Appendices	

1. Executive summary:

This report is the annual report of Guardian of Safe Working Hours (Guardian): Dr Janet Costa (Consultant General, Geriatric and Stroke Medicine), covering the period of 01 April 2022 to 31 March 2023. The report was emailed to all consultants, doctors in training and divisional rota coordinators.

This report describes the ongoing application of contractual requirements introduced in the new issue of Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016; specifically covering the elements of the Guardian of Safe Working Hours, exception reporting for variation in work hours or educational opportunities, immediate safety concerns, rota design / work schedule review, trainee post vacancies and the junior doctor forum.

In summary Milton Keynes University Hospital has provided the contractual requirements specified in the 2016 Terms and Conditions for doctors in training. Further efforts are required to ensure trainees continue to be aware of the facilities open to them, ensuring that Educational Supervisors are aware of their responsibilities and are responsive and junior doctor rota designs remain compliant with contractual requirements.

Introduction:

NHS Employers introduced a new issue of national terms and conditions for doctors in training in August 2016, which affects many factors of the working life of a doctor in training. The implementation of these terms and conditions was phased, across specialties and doctors' grades between August 2016 to August 2017, resulting in all doctors in training being covered by these terms and conditions from August 2017 with update on pay uplift on 2019 updated version.

This report covers April 2022– March 2023 and covers the system of exception reporting and the role of the Guardian.

Definitions

Work schedules – Each trainee doctor is given a document (work schedule) that describes the expected working hours, shift patterns, and pay.

Exception reports – Trainee doctors are provided with a mechanism to report (electronically) when:

> *"When their day-to-day work varies significantly and/or regularly from the agreed work schedule".*

(NHS Employers 2016, terms and conditions of service for NHS Doctors and Dentists in Training, p 31)

Exceptions are reported by the trainee and reviewed by the Educational Supervisor (typically a consultant) and an outcome agreed.

Work Schedule Reviews - A review of the rota design and staffing numbers due to exception reports.

TOIL - Time off in lieu, for extra work done at a previous time.

Fines – Fines levied by the Guardian when a service has breached the conditions set out in the August 2016 Terms and Conditions.

ISC – Immediate Safety Concern is indicated when a doctor feels there is an immediate substantive risk to safety of patients when raising an exception report.

2. Exception Reporting:

Milton Keynes University Hospital provides the following in support of the trainee doctors and the exception reporting process:

- An online exception reporting tool
- A Guardian of Safe Working Hours (consultant responsible for overseeing compliance on safe working hours)

- A Director of Medical Education (consultant responsible for overseeing the quality of educational experience)
- A Junior Doctor Forum to discuss exception reports, fines and other arising issues affecting trainee doctors at the Trust.

Number of doctors/dentists in training (total)	
Number of doctors/dentists in training on 2016 TCS (total)	161
Amount of time available in job plan for guardian to do the role	1PA of 4 hours per week
Admin support provided to the guardian (if any)	0.2 WTE
Amount of job-planned time for educational supervisors	0.25 PAs per trainee or 1 hour per week

Guardian of safe working hours report

May 2023

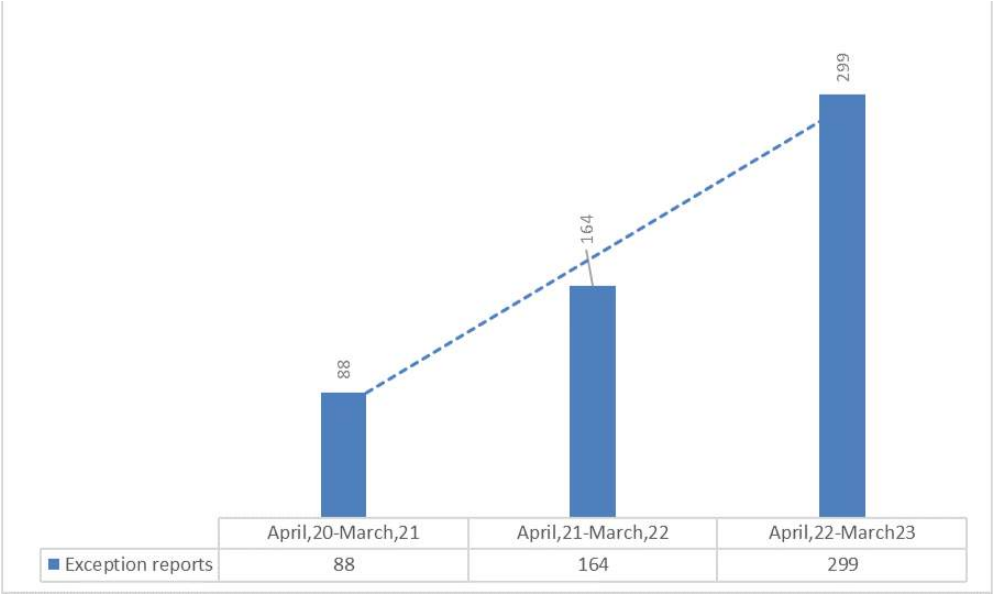
Milton Keynes University Hospital NHS Foundation Trust

I am writing to you with the yearly report on exception reporting, rota, work schedule, staffing issues, departmental updates and recent junior doctors' feedback.

2022 was a challenging year for all of us with admission pressures, waiting list demands, routine elective operations, and the psychological impact on the trainees due to work fatigue and pay disparity. A junior doctors' strike was observed for 72 hours in March 2023. This was discussed pre-strike in the junior doctors' forum with our Medical Director, a BMA representative, our junior doctors, and the guardian of safe working hours. No concerns were raised by trainees before or after the strike.

Below is the summary of the exception reports from April 2022 to March 2023.

Exception reports in the last 3 years

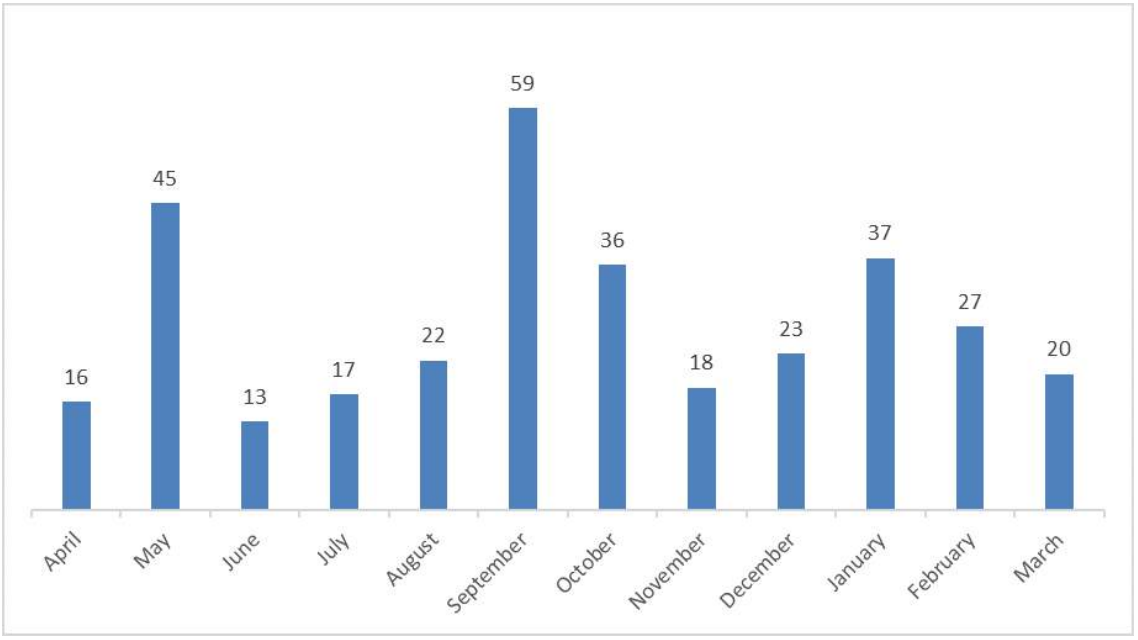


299 exception reports were raised from April 2022 - March 2023.

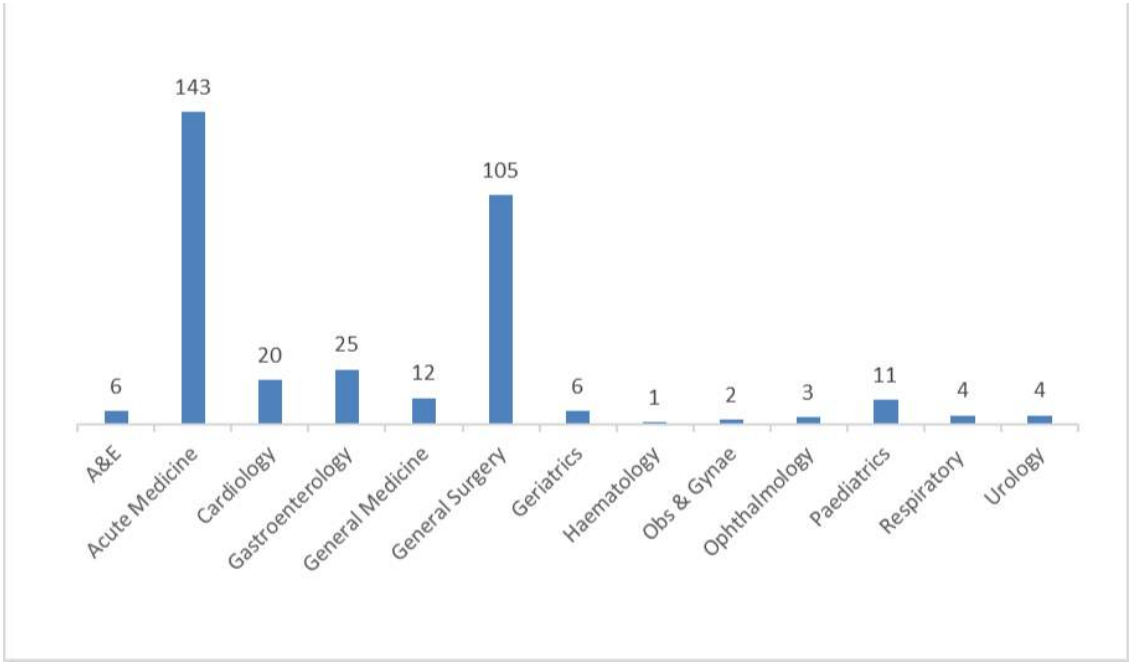
Comparison of exception reports in last 3 years

There has been a rising trend in exception reports in last 2 years, which is positive and indicates that trainee doctors are aware of the exception reporting system and using it to raise any issues related to work, education, and staffing. The number of exception reports was also low in 2020 - 2021 due to the pandemic and trainees being part of emergency rotas.

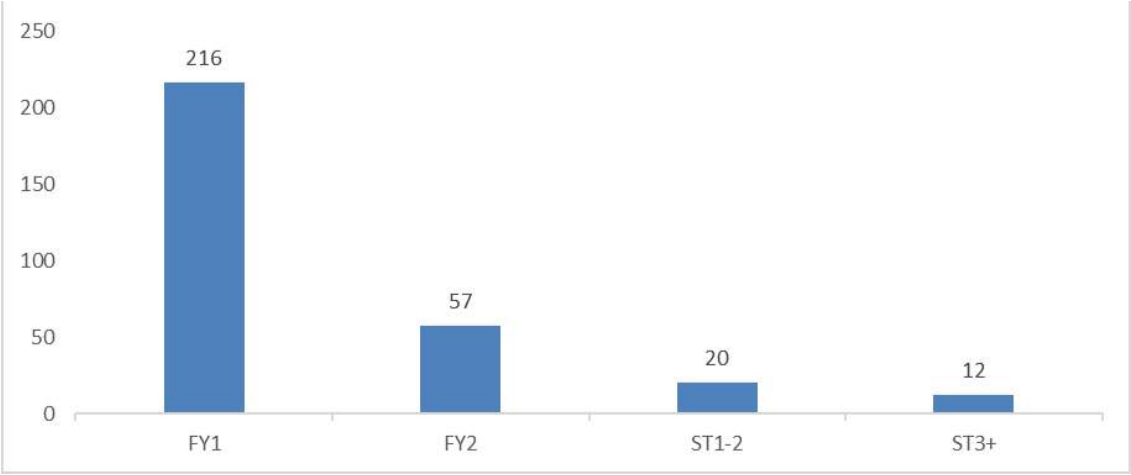
Exceptions by month:



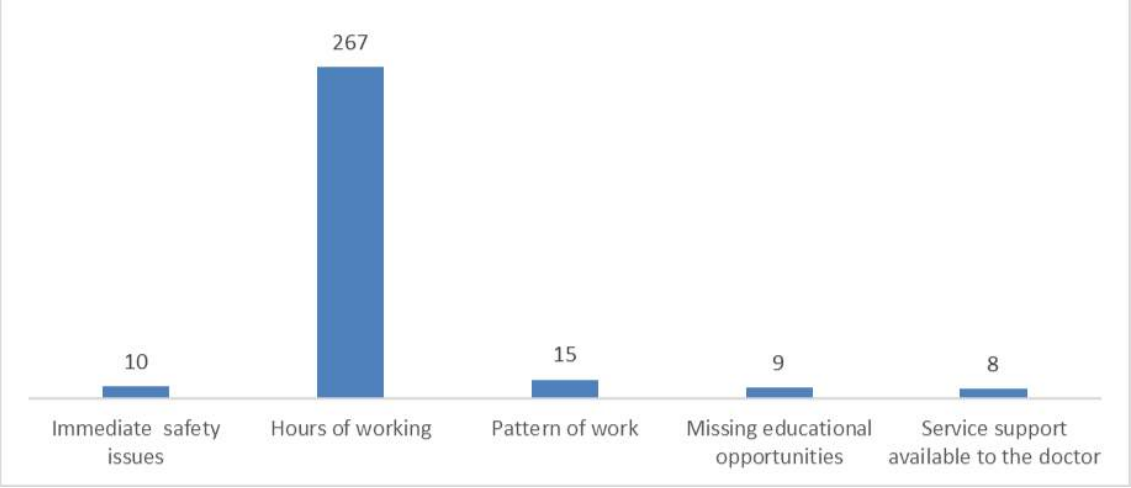
Exception reports by department:



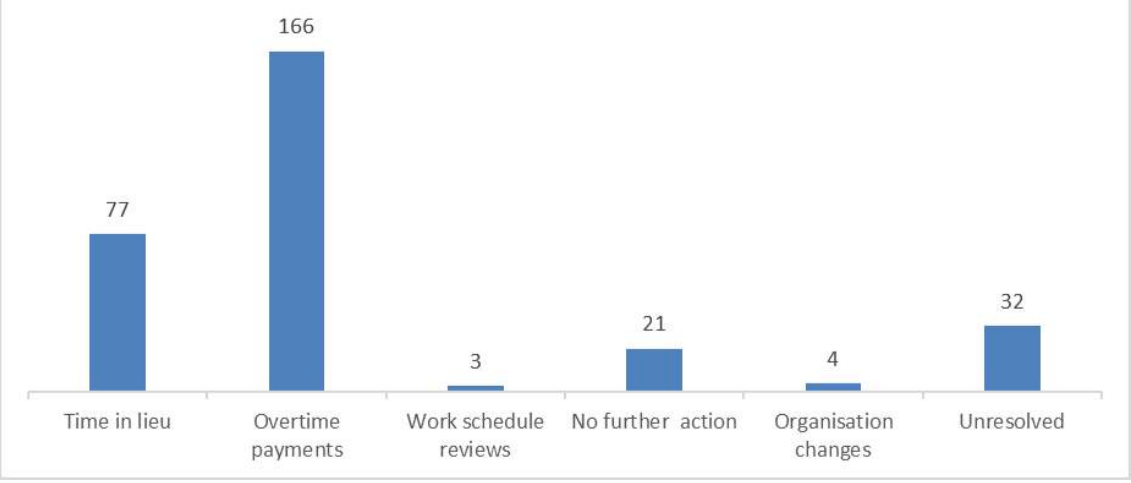
Exception reports by grade of doctor:



Reasons for exception reporting:



Outcome of exception reporting:



Summary of the reports

In summary, there were 299 exception reports from April 2022 to March 2023, which indicates adequate use of exception reporting system by junior doctors (compared to 164 in previous year). Peak months of exception reporting were May, September, and January, which does not follow any regular trend. In previous year, maximum numbers of exception reporting happened during winter months.

The exception reports were from acute medicine (47.8%) and general surgery (35%) along with other acute medical specialties Gastroenterology (8%) and cardiology (6%.). These follow the similar trend from previous years.

89% of reports were due to working additional hours i.e., staying late during ward duties on weekdays and on calls, and most quoted reasons by trainee doctors were pressure of acute patients and staffing shortages. These patterns are similar to previous years.

As per the usual trend over years, the majority of exception reports were from foundation year one doctors (72%) which reflects junior trainee doctors needing more support including adequate ward staffing and senior support, and demonstrates that junior trainee doctors are more efficient in escalating issues and are aware of the exception reporting system.

55.5% of the exception reports (166 out of 299) were resolved with payment, 25.7% (77 out of 299) were resolved with time in lieu. There were staffing level changes as explained before in the cardiology department as an outcome of the exception reports along with medicine rota changes with some increase in trust grade doctors staffing levels. There were 32 unresolved exception reports from the surgical department which have been escalated to the surgical division and await actions at the time of writing this report.

Reports with immediate safety concerns

Between 1 April 2022 and the 31 March 2023, a total of 299 exceptions were raised by trainee doctors. Of these, 10 were indicated as having immediate safety concerns (ISC).

	Grade of doctor			
Division	**Foundation Year Doctors**	**Specialty Trainee (ST1-ST2)**	**Specialty Register**	**Total**
General Surgery	5	0	0	5
Acute Medicine	4	0	0	4
Haematology	1	0	0	1

General Surgery

There were 5 exception reports with safety concerns for General Surgery, all from foundation trainee grade doctors.

Reasons

- 3 were because of severely busy on call shifts which resulted in delay in handovers and late finish from work, along with lack of rest time and feeling overworked.

- 2 exception reports were due to extremely busy weekend on call with acute patient load where surgical specialty registrar was busy in theatre, resulting in junior doctor being overworked, missing breaks, and finishing late.

Actions

All these exception reports were discussed with the trainees, clinical supervisor, and rota coordinators. Reflection was made on involving senior members of team including consultant during extreme busy period and rota team continuously monitor staffing level to ensure adequate staffing levels. Additional hours were paid.

Acute Medicine

There were 4 exception reports with safety concerns in Acute Medicine. All of them were episodes during out of hours on-call shifts.

Reasons

- 2 were due to extremely busy acute on call shift which resulted in missing breaks along with feeling overworked. A discussion was had with medical registrar on call to provide additional support.
- 1 safety concern exception was because of staff shortage due to last minute sickness over medicine weekend on call. Due to sickness, one doctor was covering 4 acute medical wards which resulted in extreme work pressure, missing natural breaks, and feeling pressured with acute works. Again, senior support and extra cover was asked for by junior doctor however this was not possible as overall, junior numbers were stretched.
- 1 exception report where one of the weekend ward cover juniors was asked to cover same day ambulatory medicine care due to high volume of patient which resulted in one junior doctor covering 4 frailty wards along with cover of acute stroke bleep. There was support from medical registrar and frailty consultant but still the volume of patient in all those wards along with cover of stroke call in ED department made for an extremely busy on-call.

Actions

All these exception reports were discussed with trainees by rota team and educational supervisors and acknowledged last-minute staff sickness and shortage. Additional hours were paid.

Haematology

There was one exception report about safety concerns from haematology foundation year doctors.

Reason

- Due to minimum numbers of junior cover on the ward. Haematology junior doctors were advised to cross cover acute oncology team as well. This resulted in additional work stress along with missing natural break.

Actions

This was reviewed by cancer management, medicine rota coordinator, and medicine and cancer division. Additional trust grade doctor, additional foundation year doctor for oncology team were allocated from August 2022 along with change in job description for the trainee junior doctor for ward 25 so that all doctors aware of holistic cross cover arrangement between oncology and haematology teams.

Exception reports due to missing educational opportunities

There were 9 exception reports last year regarding missing educational opportunities.

	Grade of doctor			
Division	**Foundation Year Doctors**	**Specialty Trainee (ST1-ST2)**	**Specialty Register**	**Total**
General Medicine	1	0	0	1
Acute Medicine	2	0	0	2
Haematology	1	0	0	1
General Practice	1	0	0	1
General Surgery	2	0	0	2
Obstetrics and Gynaecology	1	1	0	2

Exception reports due to missing educational opportunities were all because of missing opportunities to attend mandatory weekly teaching, all from variety of departments. Again, most of them (80%) were from foundation year doctors.

Reasons for missing mandatory teaching sessions were due to busy acute work schedule or being on call. All were reviewed appropriately with director of medical education, Dr Butterworth, and individual educational supervisors. Trainees were advised to complete further reports if there are recurrent episodes. A regular review been also discussed by foundation training program director to ensure foundation year doctors achieve mandatory core teaching hours and change has been made with the weekly teaching time for the foundation year 2 doctors.

Departmental work schedule review and changes implemented

Medicine rota review

As raised by trainees, there were concerns with rota, staff vacancies, and excessive workload.

1. New implementation of rota: A new rota was introduced in December 2022 with change in working hours.
2. Additional senior house officer cover at night (4 SHOs and 1 Reg).
3. Change of on call to provide adequate cover during acute medicine on call.
4. New chief medical registrar employment: Chief medical specialty registrar, Dr Robin Kearney, started in August 2022. He has contributed to the new medicine rota and improved communication between junior doctors and divisional management.

The changes have improved junior doctor satisfaction during on calls and normal working days.

Cardiology staffing level review

From January 2023 to March 2023, there were 10 exception reports from the cardiology department, highlighting the additional hours worked and junior cover on the ward. These concerns were also escalated via emails to the chief medical registrar and guardian of safe working hours Dr Costa. All exception reports and email communication highlighted:

1. Junior covers in cardiology with 2 junior grade doctors was not manageable as there was high volume of acutely unwell patients, new admission, and high turnover of patients along with planned admission of patients for cardiac procedures.
2. Junior doctors were always staying late and were not able to take any breaks while on duty.
3. It also highlighted extreme work pressure, feeling of vulnerability, and concerns of patient safety.

As per medical staffing and medicine rota team, Cardiology ward is a 27-bedded acute ward, among which 8 of them were coronary care unit beds. As per the Royal College of Physicians guideline, minimum staffing level for 30-bedded medical ward is 2 junior doctors from foundation year 1 to specialty trainee grade level, but it was not always acknowledged that Cardiology is an hyperacute medical ward which has an 8-bedded coronary care unit which provides level 2 acute care to extremely unwell cardiac patients. The opening of coronary angiogram suite for primary angiogram has and will add additional workload and patient volume with high turnover of patients.

Actions

These concerns were escalated to cardiology consultants, then to medical divisional lead, and medicine rota team. It was acknowledged that, with high patient volume and acuity of care, the minimum junior doctor staffing level on ward 17 should be 3 and above as per availability.

After implementation, with recent feedback and with exception reports data board, there has been no exception reports from cardiology in April 2023.

Oncology/Haematology staffing allocation

As per previous exception reports and trainee feedback, an additional trust grade doctor and deanery foundation doctor were allocated to ward 25. There were also changes made to the job description for trainee doctors covering ward 25 to ensure everyone is aware of cross cover between 2 specialties.

Since the changes were implemented, we have not received exception reports from the team on ward 25.

Rota, work schedule and payment review for Ophthalmology trainee doctors

An email to guardian of safe working hours by trainees and by exception reporting highlighted ophthalmology specialty trainee work schedule regarding zero-hour days after weekend non-resident on call cover. To be compliant with European working time directive, there should be additional zero hours around weekend on calls. The rota breached the 48 hours limit, with a 50-hour working week.

Actions

The rota was recalculated by medical staffing team and new trainee rota was amended. The trainees were back paid the additional hours they worked.

Fines

Fines are levied by the Guardian of Safe Working hours on departments for the following reasons:

- a breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule)
- a breach of the maximum 72-hour limit in any seven days
- minimum 11 hours' rest requirement between shifts reduced to fewer than eight
- a concern is raised that breaks have been missed on at least 25% of occasions across a four-week reference period, and the concern is validated and shown to be correct

Distribution of fined monies is then agreed at the junior doctor forum and individual doctors awarded penalty rate payments for the hours (above normal bank rate) that take them over these contractual limits. NHS employers make it quite clear that fines should be the exception and should never happen if the system of exception reporting is working (Guardian fines factsheet, NHS Employers).

Within the period of this report there have been there have been no fines.

Message to trainees

Thank you to all the trainees for your emails, face to face discussions, and completion of exception reports which really helps in identifying staffing, departmental, and educational issues and hence enables relevant implementation of changes to better training and workload.

Please continue to complete exception reports to raise any issues and, while completing, please chose the right rota team assigned to yourself and your preferred ES or CS, for timely action.

Please continue to complete exception reporting for any missing breaks, missing educational opportunities, staffing, and additional hours of work.

Information for trainers

Part of job role of all educational and clinical supervisors is to support and discuss with trainees to ensure they are working safe hours and getting all opportunities for educational activities.

Please continue to encourage and support trainees through exception reporting process and, once an email about an exception report has been received, please do discuss with trainees about their concerns and action according to the issues.

Departmental rota co-ordinators, medical staffing

To improve timely action on rota issues and working hours, and to provide adequate staffing support on areas where needed, we will continue to meet with all departmental rota co-ordinators on regular intervals.

General Surgery

As acknowledged that due to multiple changes in rota co-coordinators in surgical division, there were extreme delays in actioning exception reports and there were some exception reports which still need action and allocation of payment for the trainees.

Actions:

This is an ongoing action which will need further escalation to the surgical division as needed, and ongoing follow up with guardian of safe working hours and medical director's office.

Janet Costa
Guardian of safe working hours

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 2nd November 2023**
Report Title	**Risk Register Report**	**Agenda Item Number:**
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 31st October 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** ☑

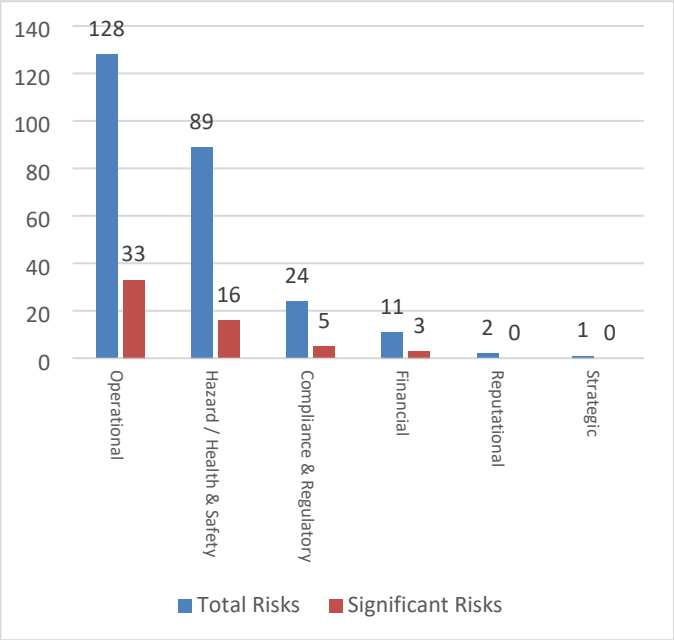
Strategic Objectives Links ***(Please delete the objectives that are not relevant to the report)***	*Objective 1: Keeping you safe in our hospital* *Objective 2: Improving your experience of care* *Objective 3: Ensuring you get the most effective treatment* *Objective 4: Giving you access to timely care*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

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

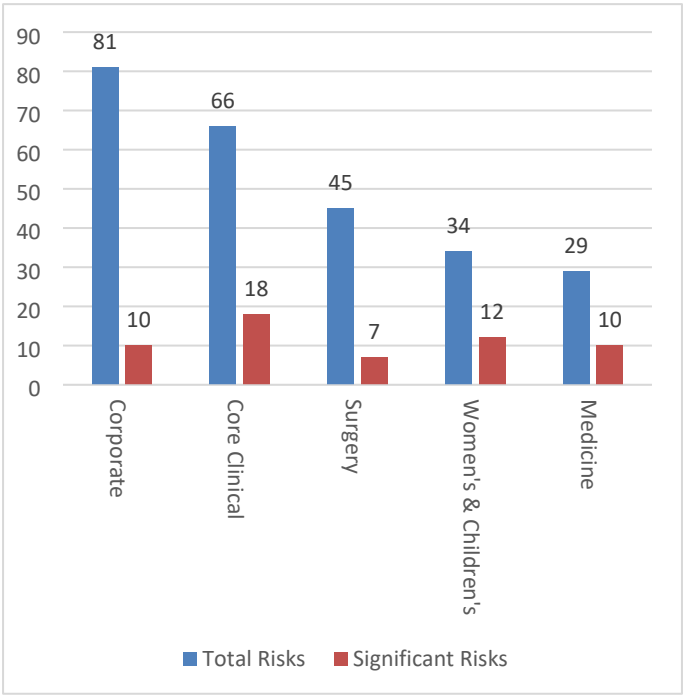


2.1 Risks by Risk Category

The Risk Category 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 217 (85%) of the 255 risks, and 49 (86%) of 57 of the Significant Risks (graded 15 or above).

Strategic risks are generally recorded on the Board Assurance Framework, so it is not unexpected that there are few strategic risks on the Risk Register.

Significant (15+) risks currently make up around 22% of all risks recorded on the risk register.



2.2 Risks by Division

The Divisional chart shows that the majority of risks identified relate to corporate departments (for example, Estates, Workforce etc). These departments represent 32% of the risks on the Risk Register. It should be noted, however, that the Divisions represent 47 (82%) of the Significant risks.

2.3 Risk Heatmaps

Likelihood \ Consequence	1	2	3	4	5
5		3	18	11	
4	1	8	36	21	4
3		11	44	23	3
2	1	11	20	20	6
1		1	1	8	4

The Current Score chart shows all 255 risks and how they are distributed in relation to their Current Risk Score.

This demonstrates that 57 (22%) risks are currently graded as significant (red) risks, 140 (55%) are currently graded as moderate (amber) risk and 58 (23%) risks are currently graded as low/very low (green) risk.

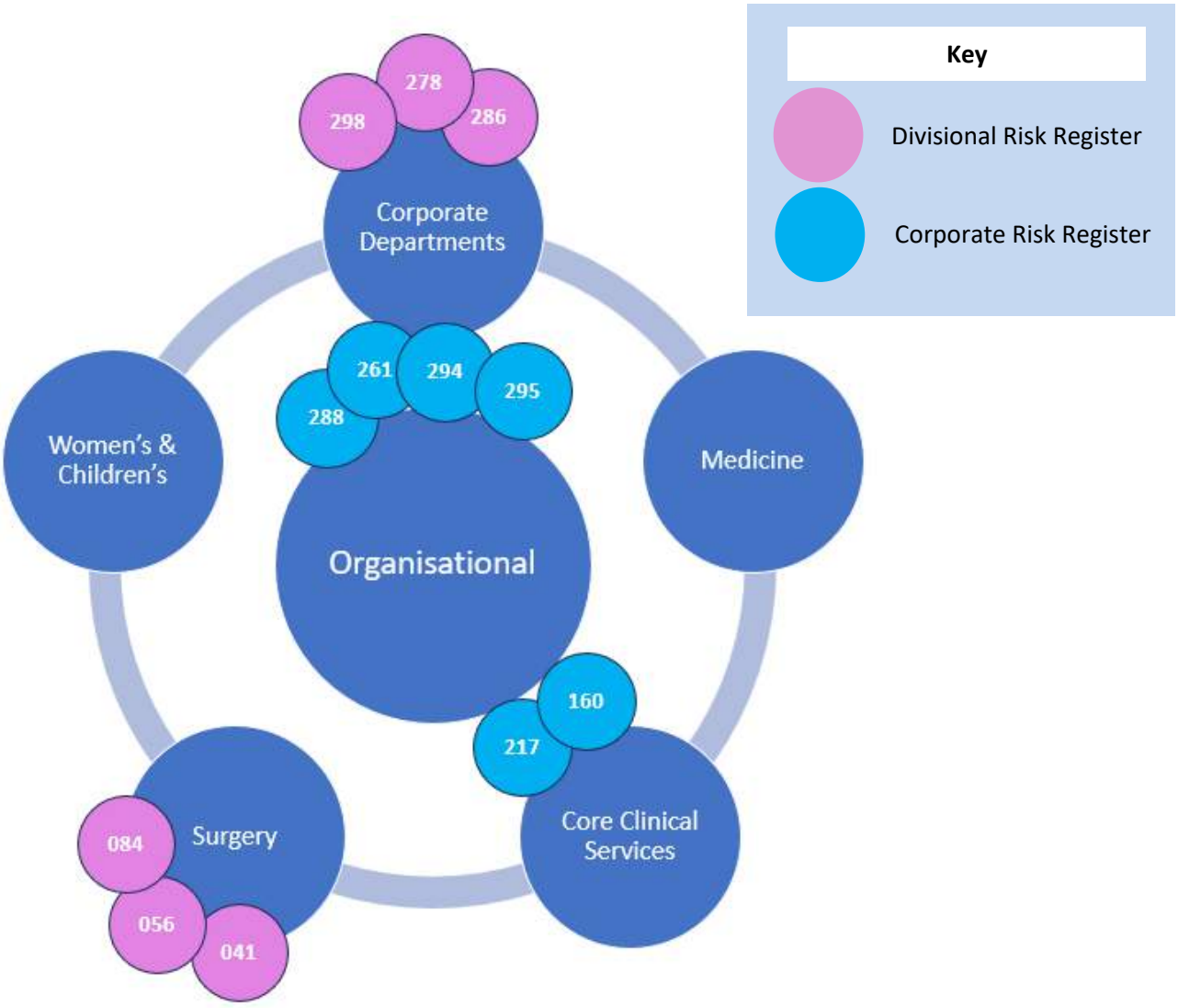
Likelihood \ Consequence	1	2	3	4	5
5					
4	3	1	4		
3	7	37	20	2	
2	5	30	41	25	6
1	3	1	23	39	8

The Target Score chart shows all 255 risks in relation to their Target Risk Score.

There are no risks where the Target Risk Score is significant. There are 58 (23%) risks that have a moderate Target Risk Score – these will need reviewed to ensure that the score aligns with Trust's risk appetite. The remaining risks a low/very low Target Risk Score.

2.3 High Consequence / Low Likelihood Risks

There are 12 risks where the potential consequence is graded a major or significant (4 or 5) and the likelihood of them occurring is rare (1). Due to the mathematics of the Risk Matrix scoring, this means that they are considered low risk; however, they have the potential to be significant risks. The below graphic demonstrates how these risks are distributed across the Divisions and which risk are on the Corporate Risk Register.

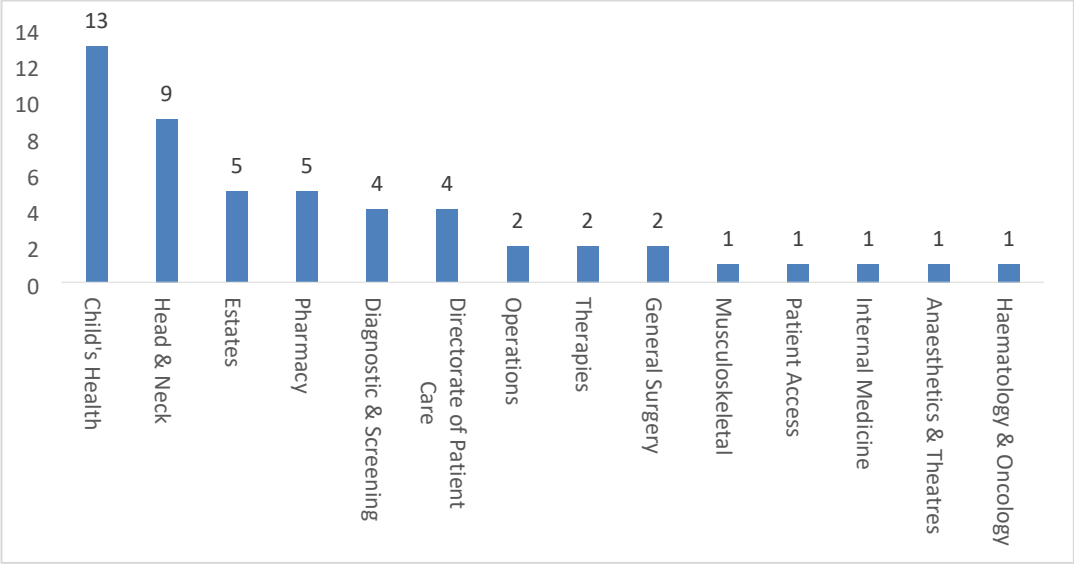


Divisional / Corporate Department Risks	Corporate Risk Register Risks
RSK-041 Specialist equipment knowledge in Theatres	**RSK-160** Bag Valve Masks similar to Lung Volume Recruitment bags
RSK-056 Single oxygen supply in Intensive Care Unit	**RSK-217** Nasogastric feeding
RSK-084 Breast Clinic capacity	**RSK-261** Inadequate PAT Testing
RSK-278 Accurate of Asbestos Register and database	**RSK-288** Medical oxygen supply
RSK-286 Inappropriate disposal of sharps	**RSK-294** Personal injury to staff
RSK-298 Estates Continuity plan may not align Trust plan	**RSK-295** Ladder safety / Injury

3. OVERDUE RISKS

At the time of reporting, there were a total of 51 risks (increase of 18) out of 255 risks (20%) overdue their review date.

3.1 Total Overdue Risks by CSU/Corporate Department



3.2 Risks Overdue Review > 1 month = 11. This is a increase of 6 since the last report.

4. NEW RISKS = 2

Radar Reference	Lead Department / CSU /Division	Risk Owner
RSK-492	Head & Neck	Louise James

5. CLOSED RISKS = 1

Radar Reference	Risk Owner	Closure Reason
RSK-310	Melissa Davis	Risk reduced as incident reporting has significantly increased

6. CHANGING RISKS

Risks that have increased: 2

RSK-312	Insufficient emergency kits in Theatres	Current Risk increase from 4 to 8
RSK-409	Demand verse Capacity in ED	Current Risk increase from 15 to 20

Risks that have decreased: 6

RSK-421	Shortages of medicines with minimal warning	Current Risk reduced from 20 to 15
RSK-067	Lack of Patient Pathway Staff	Current Risk reduced from 15 to 12
RSK-082	Trauma activity beyond capacity in Theatres	Current Risk reduced from 15 to 12
RSK-402	Lack of Orthopaedic Therapy staff	Current Risk reduced from 15 to 12
RSK-435	Access and egress to the MRI Unit	Current Risk reduced from 20 to 10
RSK-171	Space within the Pathology Department	Current Risk reduced from 12 to 9

7. RISKS FOR ESCALATION TO CORPORATE RISK REGISTER

None

8. RECOMMENDATION

The Committee is asked to review and discuss this paper.

Key recommendations/decisions for Committee:

1. The committee is asked to commission the Divisions/Corporate areas to review the risks highlighted in section 2.3 and provide feedback at the next TEC meeting, re what assurance they have that the appropriate controls in place to mitigate the risk. Where controls are outstanding, Divisions to provide an update on progress and an expected completion date.

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.

Significant Risk: There are risks where the Current Risk Score is graded 15 or above.

Reference	Category	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-134	Financial	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	12-Oct-2023	13-Nov-2023	Planned	20	20	8		Cost and volume contracts replaced with block contracts (set nationally) for clinical income(04-Nov-2021), Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until end of March 2022)(04-Nov-2021), Budgets to be reset for FY22 based on financial regime; financial controls and oversight to be reintroduced to manage financial performance(04-Nov-2021), Cost efficiency programme to be reset to target focus on areas of greatest opportunity to deliver(04-Nov-2021), The current funding has now been clarified .The trust will work with BLMK system partners during the year to review overall BLMK performance(21-Mar-2022), Internal budgetary review/financial performance oversight processes to manage/mitigate cost pressures. Financial efficiency programme identifies headroom for improvement in cost base. Close monitoring/challenge of inflationary price rises(16-Nov-2022), Financial efficiency programme identifies headroom for improvement in cost base.(04-Sep-2023), Close Monitoring/challenge of inflationary price rises(04-Sep-2023), Medium Term financial modelling commenced with ICS partners.(04-Sep-2023), Escalation of key issues to NHSE regional team for support(04-Sep-2023)	High	Treat	Risk transferred from Datix	01-Apr-2022
RSK-202	Financial	IF Financial Efficiency schemes are not fully developed THEN There is a risk that the Trust will not delver the required level of savings	LEADING TO potential cash shortfall and non-delivery of its key targets	Organisation	Karan Hotchkin	12-Oct-2023	13-Nov-2023	Planned	20	20	8		Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners(23-Nov-2021), Cross-cutting transformation schemes are being worked up(23-Nov-2021), Savings plan for 21/22 financial year not yet fully identified(23-Nov-2021), Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partner. There are no cross-cutting transformation schemes yet identified and savings of around £8m have been identified against the £12m target. Whilst this shortfall can be mitigated this year, the risk is around the underlying financial position.(16-Nov-2022)	Medium	Treat	Risk transferred from Datix	01-Apr-2022
RSK-305	Financial	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	12-Oct-2023	13-Nov-2023	Planned	16	20	9		The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021), Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24.(16-Nov-2022), The Trust has established management processes to prioritise investment of available capital resources to manage emerging risk and safety across the hospital.(04-Sep-2023), The Trust is responsive in pursuing additional NHSE capital programme funding as/when additional funding is available.(04-Sep-2023), The Trust is agile in responding to alter notified capital slippage from across the ICS and wider region to take advantage of additional capital budget(04-Sep-2023)	Medium	Treat	On-going conversations with regional and national capital team	01-Apr-2022
RSK-472	Hazard / Health & Safety	IF staff and service users (Trustwide) are subject to violence and unacceptable behaviour THEN staff/services users may sustain physical/psychological injury	LEADING TO potential significant harm; increased staff sickness/reduction in morale, recruitment and retention difficulties, lack of staff; increased length of stay for patients and poor patient experience; HSE enforcement notice; complaints and litigation; adverse publicity	Organisation	Anthony Marsh	20-Sep-2023	31-Oct-2023	Overdue	25	20	10	Wider roll out of bodycam provision, Review security provision and interim role to cover loss of PCSO Consideration of buzzer service in ED to allow patients to be called back if they take a comfort break Environmental study starting with ED (27-Oct-2023), Widen environmental study to consider patients with mental health, learning disability, dementia etc – holistic approach to care, environment, distraction therapies, Review breakaway training provision ensure rolling programme in place Update to Conflict resolution training to include what to do in the event of an incident, support, what happens next (27-Oct-2023), Embed and empower staff to report to police (27-Oct-2023), Training for staff in managing patients with mental health, learning disability, dementia etc De -escalation procedure/techniques, Clear pathway for staff support post incident through to prosecution and beyond, Development of an information pocket card for staff (27-Oct-2023), Listening events on the road, staff engagement sessions, Ensure feedback from incidents to staff and lessons learnt shared amongst wider organisation, Documented strategy Review policy	CCTV in high-risk areas(04-Aug-2023), Presence of security in Emergency Department (ED)(04-Aug-2023), Posters displayed in wards/department(04-Aug-2023), Staff communicate patient behaviours during handovers and not on patients notes(04-Aug-2023), Follow conflict resolution training(04-Aug-2023), De-escalate/Staff withdraw from situation if person becomes challenging(04-Aug-2023), Where known aggressor – dynamic assessment, have an escape route, consider seeing patient in twos, do not work alone, do not work in a closed space, consider screens/barriers between aggressor and staff, consider security presence to see patient Ensure panic alarms/call bells within easy reach Call for assistance where situations are escalating(04-Aug-2023), Application of 3 tier warning system – verbal, behavioural, red card – overseen by Head of Security(04-Aug-2023), Enforcement/criminal prosecution where possible(04-Aug-2023), Conflict resolution training mandatory for all staff and Breakaway training available adhoc(04-Aug-2023), Security available - Code victor 2222 Police available – 999 Support for staff through manager/Occupational Health & Wellbeing Services/Employee Assistance Programme Staff support through Staff Debrief available through Chaplaincy service	Low	Treat	Reviewed by Associate Director of Estates, Senior Engineer and Compliance Office. No change to current risk rating. Confirmed this risk has escalated to the Trust Risk Register, but stays with Estates as the owner.	31-Jul-2023

Reference	Category	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-001	Hazard / Health & Safety	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	04-Oct-2023	31-Jan-2024	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	Re-review once clarity on PSIRF roll out. Staff thank you e-mails sent as part of Triage pilot currently to help foster culture of reporting	06-Sep-2021
RSK-035	Operational	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	18-Sep-2023	31-Oct-2023	Overdue	20	16	6	Actively recruiting staff (18-Sep-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	Compliance & Regulatory	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	18-Sep-2023	31-Oct-2023	Overdue	16	16	6	Recruitment of staff (18-Sep-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-126	Operational	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	Overdue	25	16	9	Business Case for Refurnishing Milk Kitchen and Sluice	Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(04-Nov-2021), Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(04-Nov-2021), Added to capital plan(04-Nov-2021), Feasibility study completed(04-Nov-2021)	Low	Treat	Update required for milk kitchen	19-Dec-2022
RSK-142	Operational	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	27-Oct-2023	30-Nov-2023	Planned	15	16	6	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	Ongoing - writing business case	01-Nov-2021

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RSK-016	Operational	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-Oct-2023	12-Nov-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-033	Hazard / Health & Safety	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-158	Operational	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	23-Oct-2023	30-Nov-2023	Planned	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 (11-Oct-2023)	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)	Not Applicable	Treat	Escalation beds remain open causing increased demand for Therapy services. Vacancies are 10.7 WTE and 4.0 WTE on LTS.	27-Nov-2018
RSK-159	Operational	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	05-Oct-2023	10-Nov-2023	Planned	20	15	4	inpatient improvement programme- to ensure optimal staffing and allocation	Daily prioritisation of patients cross covering and review of skill mix locum cover x1 OT and x1 PT in place Ward book for escalation wards setup and band 7 reviews the caseload on the ward daily Monday- Friday and requests the most urgent are reviewed. Recruitment process ongoing but vacancies have reduced slightly. Over recruitment of band 5 OT and PT roles. Non-recurrent funding application for increase in therapy assistants over winter months.(12-Nov-2021), Review of Governance Structure(19-Apr-2022), Review Model of Care(19-Apr-2022), Review Equity Tool - Safe Staffing(19-Apr-2022), Review Workforce Model and Structure(19-Apr-2022), Recruitment and Retention of staff(19-Apr-2022), Education and Training of staff(19-Apr-2022), workforce plan to improve retention(09-May-2023), use of agency staff for any gapped posts(09-May-2023), each team to review skill mix to provide resilience in team, introduce support workers where required(09-May-2023), winter proposal for therapy services- enhanced number of support workers for winter period.(09-May-2023), regular attendance at MADE (Multiagency Discharge Event) to improve flow of patients and safe timely discharge.(09-May-2023)	Low	Treat	inpatient improvement programme ongoing on wards 15 7 16 and data collection for wards 18 & 19 has started. Actions from programme include: - ward based therapy team - review of referral processes - board round presence of therapy team - review of therapy interventions (PT/OT/TA) - models of care - COPD NICE guideline review OT practice contract has been extended to end of October. Vacancies have reduced to 13.1 WTE of which 5 are appointed to.	04-Mar-2019
RSK-250	Hazard / Health & Safety	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

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RSK-406	Operational	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	28-Sep-2023	31-Oct-2023	Overdue	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-421	Operational	Ongoing shortages of medicines with minimal notice or little warning	Possibility of cancellation of patient appointments/operations or a delay to treatment/discharge. Increased cost to the trust in sourcing medicines off of contract prices, courier charges, staff time	Organisation	Nicholas Beason	30-Oct-2023	25-Dec-2023	Planned	10	15	6	increase capacity of pharmacy procurement team (30-Oct-2023), Additional team members trained in procurement	Actively working on reducing any impact from medicines out of stock - sourcing where possible. Regional procurement, NHS England and mutual aid all being used.(20-Jan-2023)	Low	Treat	Risk discussed at Trust Executive Committee - Approved onto the Corporate Risk Register	27-Nov-2022
RSK-002	Compliance & Regulatory	IF recommendations and actions from audit are not evidenced, monitored and completed in the Trust; THEN required changes to practice may not implemented and we may not be meeting best practice criteria;	LEADING TO potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience), potential poor quality of service and associated impact on resources and potential CQC concerns re audit activity and learning from national audits	Organisation	Jacqueline Stretton	04-Oct-2023	30-Nov-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	Allocation of risk reallocated to match new structure of team	06-Sep-2021
RSK-003	Compliance & Regulatory	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	04-Oct-2023	31-Jan-2024	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	Ongoing work to review Radar system in house + with company. Further work required to meet PSIRF requirements	06-Sep-2021
RSK-093	Operational	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	16-Oct-2023	13-Nov-2023	Planned	16	12	6	review of patient pathways to reduce need for outpatient appointments (16-Oct-2023)	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	Insufficient to progress	01-Oct-2021
RSK-206	Financial	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	12-Oct-2023	13-Nov-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

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RSK-219	Hazard / Health & Safety	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-226	Hazard / Health & Safety	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
RSK-230	Operational	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	Pending	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-232	Operational	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	Overdue	12	12	6		Business continuity plans in some areas(25-Nov-2021), Heat wave plan(25-Nov-2021), Extreme weather policy(25-Nov-2021), Cold Weather Plan(25-Nov-2021)	Low	Tolerate	No change to risk rating	10-Apr-2022
RSK-254	Hazard / Health & Safety	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-263	Hazard / Health & Safety	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	20-Sep-2023	20-Nov-2023	Planned	20	12	8	Outstanding items from last survey to be prioritised on risk basis, on a rolling program (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, Senior Engineer and Compliance Office. No change to current risk rating.	25-Aug-2021

Reference	Category	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-264	Hazard / Health & Safety	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	20-Sep-2023	20-Nov-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, on annual business case.(29-Nov-2021), 21/22 programme approved at May 2021 Trust Exec Group(29-Nov-2021), Options for new AE, out to tender(29-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates, Senior Engineer and Compliance Office. No change to current risk rating.	29-Nov-2021
RSK-269	Hazard / Health & Safety	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	20-Sep-2023	20-Nov-2023	Planned	16	12	8	Controls and action recommendations being reviewed by Compliance Officer (24-Apr-2023), Cleaning of Phase 1 Cylinders and Calorifiers, and descaling of phase 1 calorifiers	A Water Services Management Group operates quarterly, with agreed membership and agenda items(30-Nov-2021), Audit document and action plan has been circulated to the Group for discussion and progression at the next meeting(30-Nov-2021), Independent contractor commissioned to regularly test water outlets. Controls and testing regimes in place(30-Nov-2021), Review and Water Services Management Group membership includes independent contractor and Authorising Engineer(30-Nov-2021), Whole site risk assessments are current and risk reviewed at each meeting(30-Nov-2021), Risk assessment undertaken of augmented care areas(30-Nov-2021), House keepers are flushing water out lets in clinical areas and return flushing sheets to estates, Hotel Services Audit manager to track progress and compliance(30-Nov-2021), Tender awarded to Evolution, 2 year contract commenced 1st July 2019. extended for 6 months. New tender to be drafted(30-Nov-2021), Phase 1 and Cancer Centre risk assessments completed(30-Nov-2021), Phase 2 Risk Assessment completed June 2021, actions underway(30-Nov-2021), Audit and Risk assessments for outlying buildings planned 2022(30-Nov-2021), Ben Hazell is trained and appointed Appointed Person (AP)(22-Mar-2023)	Low	Treat	Reviewed by Associate Director of Estates, Senior Engineer and Compliance Office. No change to current risk rating.	21-Dec-2022
RSK-274	Hazard / Health & Safety	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	20-Sep-2023	20-Nov-2023	Planned	15	12	6	3 year + 1 +1 . contract awarded. Annual audit of Common areas, corridors and circulation, includes repairs (26-Jun-2023)	Capital bid to be placed annually(30-Nov-2021), Ward 6 and Ward 1 full floor replacement completed(30-Nov-2021), Business Case written, funded 21/22(30-Nov-2021), Adhoc floor repairs made with temporary taping of any failures occurring(30-Nov-2021), Going to the market for new contractor, out to tender(30-Nov-2021), Crown Industrial flooring making small repairs(30-Nov-2021), Ongoing rolling annual program. Major works funded by Capital, smaller repairs funded under revenue repairs(20-Sep-2023)	Low	Treat	Reviewed by Associate Director of Estates, Senior Engineer and Compliance Office. No change to current risk rating.	25-Aug-2021

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RSK-281	Operational	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	David Field	20-Sep-2023	20-Nov-2023	Planned	12	12	9	Luing Cowley Lift awaiting upgrades, difficult as no alternative when lift not in service. (14-Nov-2022) (29-Aug-2023), Tender raised to replace control panels, hydraulic tanks (20-Sep-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)	Low	Treat	Reviewed by Associate Director of Estates, Senior Engineer and Compliance Office. No change to current risk rating.	25-Aug-2021
RSK-402	Operational	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	05-Oct-2023	10-Nov-2023	Planned	15	12	3	Recruitment of vacant posts (05-Oct-2023), Pathway review (05-Oct-2023)	Recruitment(01-Dec-2022)	Low	Treat	OT staffing has 0.5 WTE registered and 0.79 WTE non-registered vacant, PT staffing has 1.4 WTE registered vacant. Measures in place to mitigate - OT practice 3-4 days a week, B6, B5 & B4 locums in place to cover vacancies.	01-Dec-2022
RSK-424	Reputational	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	Reputational	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

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RSK-007	Hazard / Health & Safety	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	24-Oct-2023	29-Feb-2024	Planned	15	10	5		Fire Warden advised to work within current knowledge and skill gained through mandatory fire training(06-Sep-2021), No team member to attempt to fight fires with equipment untrained to use(06-Sep-2021), Risk assessment shared with team / Staff awareness(06-Sep-2021), Quarterly fire safety audits completed(06-Sep-2021), Good housekeeping practicalities - reiterated at team huddle(06-Sep-2021), Fire safety signage displayed -action cards and assembly points identified, clearly visible to team members and others visiting corridor(06-Sep-2021), Fire alarm system checked regularly in line with Trust policy and is audible in corridor(06-Sep-2021), Team members have undertaken and are up to date with mandatory training (compliance checked monthly)(06-Sep-2021), Team risk assessment for lone working on back of Covid changes which covers fire(06-Sep-2021), Risk & Clinical Governance Team Fire Warden to attend Fire Warden Training(06-Sep-2021), There was a suggestion that posters were put up for staff to follow when Kevin is not in.(21-Dec-2021), There was a recommendation that in light of the working from home arrangements, it might be appropriate for everyone to have the training so that there is adequate cover.(21-Dec-2021)	Low	Treat	Risk unchanged	06-Sep-2021
RSK-125	Operational	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	Overdue	25	10	4		COVID-19 operational and contingency plans in place(04-Nov-2021), PPE logged daily covering delivery and current stock(04-Nov-2021), National COVID Vaccine Roll Out Programme(24-Apr-2023), National COVID Vaccine Roll Out Programme(24-Apr-2023)	Low	Tolerate	No current change to risk scoring with watching brief concerning current COVID surge against national guidance and comms.	29-Apr-2020
RSK-242	Operational	IF a chemical, biological, radiological, nuclear (CBRN/HAZMAT) incident was to occur through either intentional or unintentional means THEN the Trust would require specialised response through national guidelines and expert advice	LEADING TO potential impact on Trust services and site safety to patients and staff; Possible impact on closing or disrupting ED operations, with further risk to all operations on how the Trust operate depending on the nature of the incident (e.g., Novichok incident at Salisbury)	Organisation	Adam Biggs	08-Jun-2023	22-Nov-2023	Planned	10	10	10			Low	Treat	No change to risk score against NRSA and remains an open risk due to nature of the potential incident	26-Nov-2021
RSK-260	Hazard / Health & Safety	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	20-Sep-2023	20-Nov-2023	Planned	15	10	5	Refresher Ladder Training to be arranged and delivered. Quote to be obtained from Alan Hambridge. (20-Sep-2023)	Staff training. Ladder/equipment inspections(29-Nov-2021), Written processes and Working at Height Policy reviewed regularly(29-Nov-2021), New lifting equipment purchased(29-Nov-2021), General H&S training conducted(29-Nov-2021), Cherry Picker obtained- staff trained(29-Nov-2021), RAMS from contractors reviewed by Compliance Manager(29-Nov-2021), Edge protection in place in all locations where plant or PV panels exist(29-Nov-2021), On going Contract in place for Edge Protection and Latchways systems Inspections and Maintenance.(29-Nov-2021), Trained RP in August 2021(29-Nov-2021), RP has been appointed by Alan Hambridge(29-Nov-2021), Cherry Picker is being sold, and will be replaced with a hire in service with operator as and when needed. This will negate the need for staff training, storage and maintenance of the kit, and reduce the risks to the workforce.(20-Sep-2023)	Low	Treat	Reviewed by Associate Director of Estates, Senior Engineer and Compliance Office. No change to current risk rating.	25-Aug-2021

Reference	Category	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-010	Compliance & Regulatory	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	20-Oct-2023	20-Nov-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 reviewed - no change to the risk	28-Apr-2021
RSK-233	Hazard / Health & Safety	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-Sep-2023	30-Nov-2023	Planned	16	9	3	Recruitment plans by role (18-Oct-2023), Recruitment Specialists (18-Oct-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), International Recruitment of 100 Nurses in 2023(31-Oct-2022), Recruitment and retention premia or certain specialties(11-May-2023), Advanced Nurse Practitioner development and integration in progress(11-May-2023), New SAS grade established(11-May-2023), New publication for International Medical Graduates developed(11-May-2023), Action down policy in place(11-May-2023), Routine/Regular evidence based trends inform early recruitment activity(11-May-2023), Shared recruitment campaigns for HCSW(19-Jul-2023)	Low	Tolerate	Risk merged with RSK-233.	01-Nov-2021
RSK-236	Operational	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	18-Oct-2023	31-Dec-2023	Planned	16	9	9	Creation of retention toolkit (20-Jul-2023), Staff Survey Action Plans for key areas of focus (18-Oct-2023), Review of Exit Interview process (18-Oct-2023), Review of local induction/onboarding process (18-Oct-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), Attraction Campaign to launch Autumn 2022 with programme of events and mixed media advertising through to March 2023(31-Oct-2022), Review of Retention Frameworks in Core Clinical post-implementation(20-	Low	Tolerate	Risk Reviewed - Controls updated. No change to Risk Score	02-Jan-2023
RSK-276	Operational	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	20-Sep-2023	20-Nov-2023	Planned	15	9	3	Replacement/upgrade of flat roofs identified in the 6 facet survey (24-Oct-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/ Bid not successful for roof work(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates, Senior Engineer and Compliance Office. No change to current risk rating.	21-Dec-2022

Reference	Category	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-279	Hazard / Health & Safety	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		Sloping curbs painted yellow where they may be crossed(30-Nov-2021), Fencing or railings in some areas to deter access(30-Nov-2021), Rolling Paths annual program to repair paths and roads(30-Nov-2021), Grass kept cut by grounds team(30-Nov-2021), Ongoing review of grounds to control access(30-Nov-2021), Keep off the Grass signage in place(30-Nov-2021), Areas suitable to install knee high fencing identified. To be prioritised and installed in future years.(04-Mar-2022)	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	Operational	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
RSK-283	Operational	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	28-Sep-2023	31-Oct-2023	Overdue	12	9	6		Training in the use of medical equipment(01-Jul-2022), Auditing PPMs(01-Jul-2022), Medical Devices Management policy- following processes(01-Jul-2022), Discuss at the monthly MDG meetings(31-Aug-2023)	Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-284	Operational	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	28-Sep-2023	31-Oct-2023	Overdue	12	9	6	Medical Devices Group meetings are held monthly to discuss procurement (28-Sep-2023)		Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-300	Operational	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	David Field	20-Sep-2023	20-Nov-2023	Planned	9	9	3	Above the line funding for 2 x wards and ED agreed for 2021 with Ascom. Ward 2A and ED will be completed in 2023/2024 (20-Sep-2023), 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)	Low	Treat	Reviewed by Associate Director of Estates, Senior Engineer and Compliance Office. No change to current risk rating.	25-Aug-2021
RSK-432	Compliance & Regulatory	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	05-Oct-2023	12-Apr-2024	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-434	Operational	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
RSK-448	Operational	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	04-Sep-2023	01-Nov-2023	Pending	9	9	6	Replacement obstetric ultrasound machines (05-Oct-2023)	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

Reference	Category	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-020	Hazard / Health & Safety	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-Oct-2023	12-Nov-2023	Planned	9	8	1	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-211	Hazard / Health & Safety	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	02-Oct-2023	25-Oct-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	Risk reviewed, no change to risk	16-Mar-2021
RSK-257	Operational	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-262	Hazard / Health & Safety	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	20-Sep-2023	20-Nov-2023	Planned	20	8	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, Senior Engineer and Compliance Office. Reduced risk rating from 12 to 8. As all known issues have been resolved. Rolling program of review and repair.	25-Aug-2021
RSK-265	Hazard / Health & Safety	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	David Field	20-Sep-2023	30-Sep-2024	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, Senior Engineer and Compliance Office. No change to current risk rating. Changed review frequency to annual, due to the main exits and hospital streets have all been updated.	25-Aug-2021

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RSK-266	Financial	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-291	Operational	IF the existing surface water drainage system is not suitably maintained or repaired THEN the surface water drainage system could fail	LEADING TO flooding and contamination and loss of service	Organisation	Michael Stark	23-Mar-2023	31-Mar-2024	Planned	12	8	4	Annual drain survey scheduled to identify remedial works (31-Mar-2023)	Reactive maintenance repairs(30-Nov-2021), CCTV works has indicated areas of root re-growth with pipe damage to storm water pipes, works being undertaken during summer/autumn 2021(30-Nov-2021), BDP created scope for full site survey under the HIP program to identify shortfall in current data and future plan requirements. A new link is likely to be required as part of South Site development(30-Nov-2021), Road Gulley on PPM(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	25-Aug-2021
RSK-293	Operational	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	David Field	20-Sep-2023	30-Sep-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, Senior Engineer and Compliance Office. No change to current risk rating. Updated risk owner	25-Aug-2021
RSK-301	Operational	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-423	Operational	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	16-Oct-2023	13-Nov-2023	Planned	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	Supplier shortages are continuing	24-Jan-2023
RSK-005	Hazard / Health & Safety	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	04-Oct-2023	31-Jan-2024	Planned	12	6	3		Trust Documentation Policy(06-Sep-2021), Library resource to source current references(06-Sep-2021), Governance Leads provide support to staff reviewing guidelines and policies(06-Sep-2021), Monthly trust documentation report shared with Governance Leads(06-Sep-2021), New process via Trust Documentation Committee for 'removal' of significantly breached documents(06-Sep-2021), Work plan in place to check approval of documents/links to national leaflets(06-Sep-2021), Implementation of Radar Document Management System to improve engagement and access to the documentation process(06-Sep-2021)	Low	Treat	Trust transition to Radar module for document management Number of breached documents remains an issue - risk unchanged	06-Sep-2021
RSK-115	Compliance & Regulatory	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	25-Sep-2023	22-Dec-2023	Planned	20	6	4	AE(D) to appoint AP(D) for Endoscopy.	Estates management informed and plans in place to receive reports on time and to standard. Independent monitoring system in place monitoring machine performance. Weekly PPM carried out on machinery. An action plan has been created by estates, to include training the specialist estates officer so he can gain the recognised qualification he needs to carry out the role of the Authorised person for decontamination (AP(D)) and for additional training of the estates competent persons (CP(D) who test the decontamination equipment.(29-Oct-2021), A meeting took place in January with estates managers, where HSDU were seeking assurance that the service would be covered. Estates have agreed to look for a plan to mitigate the risk and to keep HSDU fully informed. HSDU have informed the AE(D), so he is now aware that the site will not have any day to day operational AP(D) cover. Estates nominated person AP is undergoing training and awaiting final sign off and official appointment to role.(21-Jan-2022), Mechanical Engineer is trained and appointed as AP, for HSDU.(04-Apr-2023), Appointed AP(D)(27-Jul-2023)	Low	Treat	still no AP(D) for endoscopy decontamination. Validation reports from the AE(D) are not being signed off on time	25-Aug-2021

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RSK-204	Financial	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	16-Oct-2023	16-Oct-2024	Planned	16	6	6		All staff attend an annual mandatory training course on Information Governance(23-Nov-2021), Staff are encouraged to use catalogues which reduces the requirements for free text(23-Nov-2021), Data sent out to external agencies is checked for any patient details before submitting(23-Nov-2021)	Medium	Tolerate	Ongoing risk	01-Apr-2022
RSK-205	Financial	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	16-Oct-2023	16-Oct-2024	Planned	12	6	6		Monthly reviews on data quality and corrections(23-Nov-2021), Mechanisms are in place to learn and change processes(23-Nov-2021), Data validation activities occur on monthly basis(23-Nov-2021), A desire to put qualifying suppliers in catalogue(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix	01-Apr-2022
RSK-207	Operational	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	12-Oct-2023	13-Nov-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	Financial	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	12-Oct-2023	13-Nov-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-216	Hazard / Health & Safety	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, Nurse and Midwife(24-Nov-2021), Named Executive lead for Safeguarding(24-Nov-2021), Ongoing training programme for all staff(24-Nov-2021)	Low	Tolerate	Risk owner updated to Julie Orr	24-Nov-2021
RSK-229	Compliance & Regulatory	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
RSK-238	Hazard / Health & Safety	IF poor moving and handling practice happens, THEN staff and patients may get injured due to poor moving and handling	LEADING TO litigation, sickness absence and increased temporary staffing backfill. Staff and/or patient injury Subsequent reduction in staff numbers Poor reputation and publicity Potential risk of litigation and prosecution	Organisation	Louise Clayton	18-Oct-2023	30-Nov-2023	Planned	12	6	6	Set up standing agenda for Manual Handling Steering Group, Triangulate Data, Create action plans for top areas identified through group	Currently manual handling training is carried out every three years and the Manual Handling and Ergonomics Advisor visits all departments to carry out risk assessments, offer advice and ad-hoc training as required(25-Nov-2021), Training is currently being provided ad-hoc by an external company(10-May-2022), Occupational Health are employing a MSK Physio to provide staff support post injury.(10-May-2022), The Trust is exploring bank contracts for trainers to meet demand(10-May-2022)	Low	Treat	Risk reviewed - Controls updated	01-Nov-2021

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RSK-252	Hazard / Health & Safety	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-258	Operational	IF the Switchboard resources cannot manage the service activity THEN this may result in poor performance	LEADING TO failure To meet KPI's and Emergency Response Units will put Patients, Staff and Visitors at risk and Communication with Users will give poor perception of the We Care action initiative	Organisation	Alan Brooks	20-Sep-2023	20-Nov-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, Senior Engineer and Compliance Office. No change to current risk rating.	25-Aug-2021
RSK-272	Operational	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	David Field	20-Sep-2023	20-Nov-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), Remedial works are prioritised on a risk basis. Business case foe funding produced, variation to be updated(20-Sep-2023)	Low	Tolerate	Reviewed by Associate Director of Estates, Senior Engineer and Compliance Office. No change to current risk rating.	25-Aug-2021
RSK-273	Compliance & Regulatory	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 (28-Sep-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), Loan Medical Equipment Arrangement with Supplier(01-Sep-2023)	Medium	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-299	Hazard / Health & Safety	IF the Summary Record of Estates 5 year and Prioritised Backlog Maintenance risk based priority programme is not fully implemented THEN plant and equipment may fail in various areas of the hospital	LEADING TO infection control, financial implications, loss of services and reputation damage	Organisation	Anthony Marsh	23-Mar-2023	31-Mar-2024	Planned	9	6	4	Ongoing reviews, identified backlog issues driving Capital Plan. Outstanding funding of Capital works required. Operational impact of significant works to be considered. (26-Jun-2023), New Hospital Programme guidance indicates funding to clear CIR backlog programme to be included as part of the project. (26-Jun-2023)	All areas are reviewed on a monthly basis by Estates Service Manager, or sooner if equipment/plant breakdown demands(30-Nov-2021), Business cases for plant replacement to be put forward FY21/22(30-Nov-2021), Compliance Officer reviewing to identify significant costs(30-Nov-2021), Annual review of recent 6 Facet Survey to identify future funding requirements e.g. Roof, Ventilation, Plant, HV, drainage(30-Nov-2021), n/a(30-Nov-2021), Annual Physical 20% of site 6 facet survey undertaken, remainder of site updated with desktop exercise(03-Mar-2022)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	25-Aug-2021
RSK-217	Hazard / Health & Safety	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	04-Oct-2023	04-Oct-2024	Planned	15	5	5		All NPSA recommendations were acted upon in 2011 in the Trust as per NPSA requirements by the ANP for Nutrition(24-Nov-2021), Nutrition Committee overseeing this alert and is standard item on agenda from Dec 16. Clinical Medical and Nutritional ANP leading on the action plan(24-Nov-2021), Policies, protocols and bedside documentation reviewed to ensure compliance(24-Nov-2021), Ongoing programme of audit. Previous audit data presented to NMB Spring 2016(24-Nov-2021), Dietetic Amalga database identifies patients who require Nasogastric feeding(24-Nov-2021), Trust declared compliance with 2016 Nasogastric Tube Misplacement: Continuing Risk of Death or Severe Harm Patient Safety Alert (NHS/PSA/RE/2016006)(24-Nov-2021), The NG tube used by the trust was changed in 2020 to a tube that is more radiopaque and is therefore easier to interpret on X-ray(24-Nov-2021), pH strips are purchased from one supplier to avoid confusion with colour interpretation(24-Nov-2021), Two nutrition nurses available to place NG tubes if there are no trained clinical staff available(24-Nov-2021), Radiographers trained to interpret x-rays for confirmation of NG tube tip position. This speeds up reporting and avoids junior medical staff having to assess X-rays(24-Nov-2021)	Low	Tolerate	Risk reviewed at Therapies CIG - No change to risk	23-Apr-2014

Reference	Category	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-120	Operational	IF medical devices are not correctly cleaned/disinfected/decontaminated/sterilised THEN the devices will not be sufficiently cleaned	LEADING TO possible patient and staff safety issues and cross contamination	Organisation	Marea Lawford	14-Mar-2023	03-Jan-2024	Planned	9	4	4	monitor and increase score should it be required to do so. this is not seen as a likely risk (05-Jan-2023)	The trust has a decontamination policy which states how equipment can be risk assessed to ensure that the correct methods of cleaning are used.This is on the hospital intranet and can be accessed by all staff. The hospital has two departments HSDU and Endoscopy Decontamination both of which are accredited to ISO 13485 and these units process a vast majority of the medical devices used on a patient. Low risk items are usually dealt with on the wards and the Decontamination policy covers this. Any specialist equipment used in wards and departments is identified at the point of purchase using the PPQ to determine what methods of decontamination are required. If this equipment is unsuitable for reprocessing through HSDU or Endo Decon then a individual risk assessment will need to be completed. Guidance on this can be gained from IPCT, the Decontamination Lead, EBME and the Medical equipment manager. A decontamination group meets quarterly and ward managers/HOD's are requested that any items decontaminated on the wards are bought to the attention of the group in order to ensure that the correct methods are being used.(29-Oct-2021)	Low	Tolerate	risk is low and deemed acceptable.	05-Jan-2023
RSK-160	Hazard / Health & Safety	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	07-Sep-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 to eliminate the risk of it accidentally being used in a resus situation.(12-Nov-2021)	Low	Tolerate	No changes to risk score, continue to review 3 monthly. No incidents identified.	17-Jan-2020
RSK-214	Operational	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	04-Sep-2023	30-Nov-2023	Planned	15	4	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	Vacancies low in Medicine	24-Nov-2021
RSK-215	Compliance & Regulatory	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-237	Strategic	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	18-Oct-2023	31-Dec-2023	Planned	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 (28-Sep-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-261	Hazard / Health & Safety	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	David Field	20-Sep-2023	30-Sep-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, Senior Engineer and Compliance Office. No change to current risk rating. Updated risk owner	29-Nov-2021

Reference	Category	Description	Impact of risk	Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-288	Hazard / Health & Safety	IF the medical oxygen supply fails to function or becomes non-compliant with HTM requirements THEN the oxygen plant may not be available	LEADING TO potential loss of service, reduced patient safety and substandard care	Organisation	Michael Stark	23-Jun-2023	31-Mar-2024	Planned	12	4	4		PPM Schedule, and reactive repairs as required(30-Nov-2021), Robust contingency plan is in place with liquid O2(30-Nov-2021), Steve Goddard has been appointed as Authorised Engineer(30-Nov-2021), Estates Officer has been appointed as AP(30-Nov-2021), SHJ appointed as maintenance contractor(30-Nov-2021), AP training booked for and additional estates officer and estates service manager(30-Nov-2021), VIE capacity upgrade 2021(30-Nov-2021), Draft feasibility to achieve second VIE, and conversion of site to ring main, linked to HIP programme(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021
RSK-294	Hazard / Health & Safety	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	Hazard / Health & Safety	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-008	Compliance & Regulatory	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	25-Sep-2023	25-Dec-2023	Planned	15	2	1		Governance Team putting forward deaths for Structured Judgement Reviews (SJRs) based on previously agreed clinical criteria e.g. sepsis related(06-Sep-2021), Learning from Deaths policy as a tool to indicate required processes and cases that require review(06-Sep-2021), Implementation of the new system - CORs(06-Sep-2021), M&M review meetings on a regular basis with all required SJRs completed(01-Apr-2022)	Medium	Treat	Upgraded IT mortality tracking solution expected to be functional by Dec 23	06-Sep-2021

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board of Directors	**Date:** 02 November 2023
Report Title	Board Assurance Framework	**Agenda Item Number: 24**
Lead Director	Kate Jarman, Chief Corporate Services Officer	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	Assurance Report		
Key Messages to Note	The Committee is asked to review and make recommendations as appropriate, note the following: • Please note the highlighted update on the Industrial Actions and the mitigating actions thereof (**BAF Risk 1 – Page 8**); • Please note the highlighted update on the 'Exec to Exec Commitment' to develop head and neck services in Milton Keynes (**BAF Risk 5 – Page 19**).		
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	N/A
Next Steps	Finance and Investment Committee, October 2023
Appendices/Attachments	Board Assurance Framework

Risk Seminar Report and Actions

Members and attendees of the Audit Committee attended a risk workshop on Monday, September 4, to discuss developing risk management in response to the external risk environment and good practice. The Trust's internal auditors attended to share industry best practice.

The discussion was wide-ranging and covered the following key points:

Risk Management

- Reporting to Board must be meaningful and easily interpretable – reports require trend analysis, risk profiling over time, should be data led and include graphical analysis and comparison
- The risk register should be view as a general ledger, i.e. it is transactional and will change daily
- Currently difficult to assess whether overall risk is going up or down in the hospital and if there are any hotspots – more interpretation and analysis in reporting will help (i.e. more interpretative reporting rather than presentation of the entire risk register)
- The central risk function could and arguably should be more directive – requiring action and assurance rather than reporting on compliance
- Need to provoke – a general sense (supporting the bullet above) that the risk function should provoke action
- The Board would benefit from greater oversight of emergent risks e.g. high consequence, low likelihood
- The bullet above led to a discussion on using a new risk matrix which includes an impact score (internal audit to share)
- Reporting should include the triangulation of risk registers with incidents, complaints, audit (and other quality metrics) – an integrated quality/ clinical governance/ assurance report was agreed as an output
- A further Board workshop on risk – internal audit led – was also agreed as an output and will be scheduled with the Chair

Board Assurance Framework

- An exec/NED to exec/Ned discussion with BLMK on system risk was agreed as an output of the meeting – this is particularly to understand shared risk, system risk and how risk will be managed across the system (e.g. role of system Audit/ Risk Committee and any committees in common that may develop over time) and mapping system risks explicitly back to the BAF
- Discussion on making the BAF more strategic in terms of context/ content, including developing a covering report with narrative on risk profile, risk environment and emergent strategic risk – this was agreed as an output
- Discussion on check and challenge with CEO/ execs before Board meeting – opportunity for agenda shaping
- Discussion on how is risk dealt with at Committee level – Audit Committee to set expectation to Committees for how they will deal with risk

Actions and Delivery Timeframes

Action	Delivery Timeframe	Responsible Officers
Risk management development work – including a revised risk report to Board	January 2024	Chief Corporate Services Officer, Trust Secretary and Risk Manager
BAF covering report on risk environment and risk profile	January 2024	Chief Corporate Services Officer, Trust Secretary and Risk Manager
System risk work	Initial meeting held between Audit Committee chairs (MKUH and ICB) – joint workshop to be scheduled (date tbc)	Chief Corporate Services Officer to arrange
Board seminar on risk	February 2024	Chief Corporate Services Officer, Trust Secretary and Risk Manager
Integrated governance report to Board	February 2024 (seminar before March public Board)	Chief Corporate Services Officer

Monthly Report to Board

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

Strategic Objectives

1. Keeping you safe in our hospital
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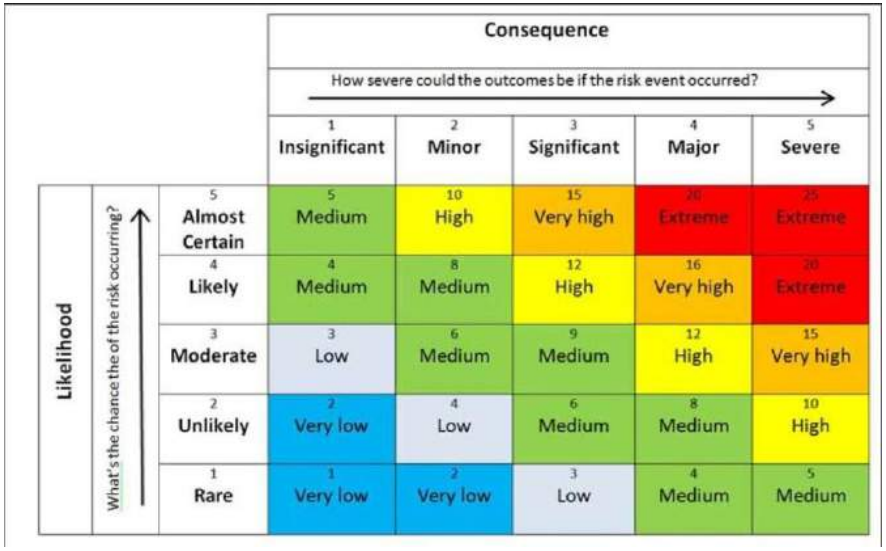
Risk treatment strategy: Terminate, treat, tolerate, transfer

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:

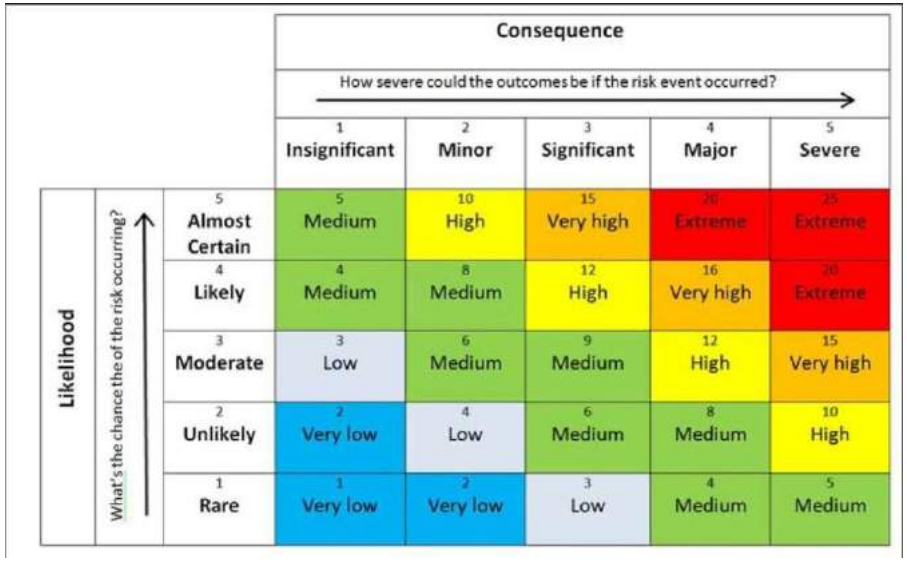


Six to 12 Month Risk Profile (2023)

There are currently 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
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

Risk Profile



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

Current Risk Profile (October 2023)

	1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
5 Almost Certain				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.	
4 Likely					Patients experience poor care or avoidable harm due to delays in planned care Patients experience poor care or avoidable harm due to inability to manage emergency demand Insufficient capital funding to meet the needs of population we serve Suboptimal head and neck cancer pathway
3 Moderate					
2 Unlikely					Insufficient staffing levels to maintain safety
1 Rare					

RISK 1: Insufficient staffing levels to maintain safety

Strategic Objectives

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7. Spending money well on the care you receive
8. **Employing the best people to care for you**
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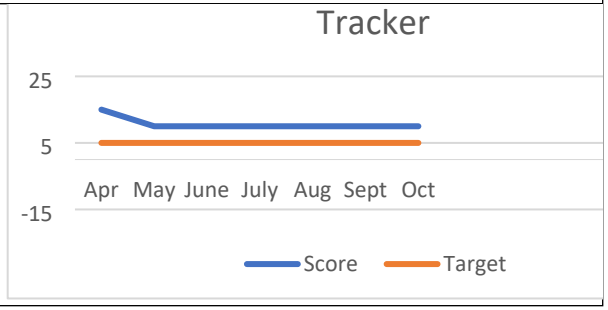
Strategic Risk	If staffing levels are insufficient in one or more ward or department, then patient care may be compromised, leading to an increased risk of harm					
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief People Officer	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment	December 2022	**Likelihood**	2	1	**Risk Treatment Strategy**	Treat
Date of Review	02/10/2023	**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 **Third line of defence:** Internal audit	**Second line of defence:** **Third line of defence:**	

Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
5. Industrial Action	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 Industrial Action (IA) • Rota management in advance of known IA • Process for understanding employee intention to strike – ensuring adequate cover • Derogations in place in cases of					

	safety concerns.					

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

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

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

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

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

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

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

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

Strategic Objectives

1. **Keeping you safe in our hospital**
2. **Improving your experience of care**
3. **Ensuring you get the most effective treatment**
4. **Giving you access to timely care**
5. Working with partners in MK to improve everyone's health and care
6. Increasing access to clinical research and trials
7. Spending money well on the care you receive
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 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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6. Increasing access to clinical research and trials
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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	Chief Finance Officer	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	19/10/23	**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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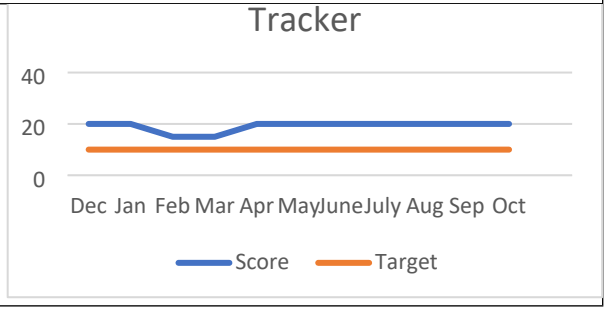
Strategic Risk	If the pathway for patients requiring head and neck cancer services is not improved, then users of MKUH services will continue to face disjointed care, leading to unacceptably long delays for treatment and the risk of poor clinical outcomes					
Lead Committee	Quality & Clinical Risk	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief Medical Officer	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat
Date of Review	16/10/2023	**Risk Rating**	20	10	**Assurance Rating**	



Cause	Controls	Gaps in Controls	Action Required	Sources of Assurance	Gaps in Assurance	Action Required
Milton Keynes University Hospital NHS FT does not provide head and neck cancer services but acts as a spoke unit to the hub at Northampton. Northampton faces:	Milton Keynes University Hospital NHS FT (MKUH) clinicians have escalated concerns (both generic and patient specific) to the management team at Northampton. MKUH clinicians are advocating 'mutual aid from other	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 Joint commitment confirmed at Milton Keynes University Hospital NHS FT /Oxford University Hospitals NHS FT exec-to-exec team meeting on 02 October 2023	Ongoing delays in response from Oxford University Hospitals NHS FT to NHSE on the potential way forward and the suboptimal process in terms of collaboration / engagement with Milton Keynes University Hospital NHS FT on the proposed service model. Continued concerns with delays in patient pathways and a failure to fully implement the recommendations of the serious incident review investigation commissioned by NHS Midlands (reported November 2022).		**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

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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	Chief Finance Officer	**Consequence**	4	4	**Risk Appetite**	Cautious	
Date of Assessment	March 2023	**Likelihood**	5	2	**Risk Treatment Strategy**	Treat	
Date of Review	19/10/23	**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	Ability to influence (negotiate) and mitigate inflationary price rises is modest at local level.	Work with ICS partners and NHSE to mitigate financial risk.	**First line of defence:** Financial performance	**First line of defence:** • Systematic monitoring of inflationary price	Establish process for oversight of

Additional premium costs incurred to treat accumulated patient backlogs. Prolonged premium pay costs incurred in a challenging workforce environment, including impact of continued industrial action. Increased efficiency required from NHS funding regime to support DHSC budget affordability and delivery of breakeven financial performance. Risk of unaffordable inflationary price increases on costs incurred for service delivery. Affordability of 2023/24 planning objectives (e.g., backlog recovery) in context of draft financial regime for 2023/24	manage/mitigate cost pressures 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	Closely monitor inflationary price rises and liaise with ICS and NHS England. Timely identification and escalation of emerging risks for management decision	oversight at budget 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	changes in non-pay expenditure. • Limited ability to directly mitigate demand for unplanned services.	inflationary price 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:**	

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board of Directors**	**Date: 02 November 2023**
Report Title	**Revised Terms of Reference – Board of Directors**	**Agenda Item Number: 25**
Lead Director	Kate Jarman, Director of Corporate Affairs	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	Assurance		
Key Messages to Note	No significant changes, apart from changes to the titles of Executive Directors.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** x	**For Review** ☐

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

Report History	*N/A*
Next Steps	*N/A*
Appendices/Attachments	*Revised Terms of Reference*

Milton Keynes University Hospital NHS Foundation Trust

Board of Directors
TERMS OF REFERENCE

1. Constitution

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

2. Authority

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

3. Accountability

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

4. Duties

4.1 The Board of Directors will exercise the powers of the Foundation Trust, as set out in the 2006 NHS Act, Health and Social Care Act ~~2012~~ 2022 and as stated in the Trust Constitution (paragraph 3.2):

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

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

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

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

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

- review the Trust's Registration and compliance monitoring arrangements

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

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

5. Risk Management

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

6. Membership

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

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

- a Non-Executive Chair
- 7 other Non-Executive Directors
- the Chief Executive
- 6 voting Executive Directors including the positions of ~~Medical Director~~Chief Medical Officer, ~~Director of Patient Care and Chief Nurse~~Chief Nursing Officer, Deputy Chief Executive, ~~Director of Finance~~Chief Finance Officer, ~~Director of Operations~~Chief Operating Officer and ~~Director of Workforce~~Chief People Officer.

The above comprise the voting membership of the Board of Directors

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

- any associate Non-Executive Directors
- any other Executive Directors

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

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

meeting and provide appropriate advice and support to the Chair and Board members.

7. Responsibilities of Members

7.1 Members of the Board of Directors have a responsibility to attend at least 75% of meetings, having read all papers beforehand

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

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

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

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

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

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

8. Frequency of Meetings

8.1 Meetings will normally take place every two months. Meetings may take place more frequently at the Chair's discretion

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

9. Committee Administration

9.1 Committee administration will be provided by the Trust Secretariat

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

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

10. Review

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

Version Control

Draft or Approved Version:	DRAFT
Date:	~~August~~ October 2023~~1~~
Date of Approval:	0~~29 September~~ November 2023~~1~~
Author:	Trust Secretary
To be Reviewed by:	Trust Board
To be Approved by:	Trust Board
Executive Responsibility:	~~Director of Corporate Affairs~~Chief of Corporate Services

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board of Directors**	**Date: 02 November 2023**
Report Title	**Revised Terms of Reference – Audit Committee**	**Agenda Item Number: 25**
Lead Director	Kate Jarman, Director of Corporate Affairs	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	Assurance		
Key Messages to Note	Area reviewed and discussed by the Committee were: a. Attendance (List)		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** x	**For Review** ☐

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

Report History	*Audit Committee, September 2023*
Next Steps	*Trust Board of Directors, November 2023*
Appendices/Attachments	*Revised Terms of Reference*

Milton Keynes University Hospital NHS Foundation Trust

AUDIT COMMITTEE
TERMS OF REFERENCE

1. Constitution

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

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

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

2. Delegated Authority

The Committee has the following delegated authority:

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

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

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

3. Accountability

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

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

4. Reporting Lines

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

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

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

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

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

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

5. Purpose

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

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

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

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

6. Duties of the Audit Committee

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

6.1 Integrated Governance, Risk Management and Internal Control

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

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

- the Board Assurance Framework;
- the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible;

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements in the above;
- the policies for ensuring compliance with NHS Improvement and other regulatory, legal and code of conduct requirements;
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority;
- the Trust's insurance arrangements.

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

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

6.2 Internal Audit

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

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- reviewing and approving the Internal Audit programme and operational plan, ensuring that this is consistent with the audit needs of the organisation
- reviewing the major findings of internal audit work, management's response, and ensuring co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- reviewing the responses by management to the internal audit recommendations
- annually reviewing the effectiveness of internal audit

6.3. External Audit

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

- considering the appointment and performance of the External Auditor
- discussing and agreeing with the External Auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan.

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

6.4 Whistleblowing

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

6.5 Other Assurance Functions

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

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

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

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

6.6 Counter Fraud

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

7. Membership

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

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

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

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

7.4 At least one member of the Audit Committee must have recent and relevant financial experience. Other members of the Committee must receive suitable training and induction on taking on their role.

8. Attendance

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

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

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

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

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

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

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

9. Responsibilities of Members, Contributors and Attendees

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

9.2 Officers presenting reports for consideration by the Committee should submit such papers to the Trust Secretary by the published deadline (at least 7 days before the

meeting). Papers received after this deadline will normally be carried over to the following meeting except by prior approval from the Chair;

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

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

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

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

10 Information Requirements

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

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

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

• key issues emerging from the work of internal audit;

• management response to audit recommendations;

• any changes to the agreed internal audit plan; and

• any resourcing issues affecting the delivery of the objectives of internal audit;

• a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the National Audit Office, for example, Value for Money reports and good practice findings);

• management assurance reports; and

• reports on the management of major incidents, "near misses" and lessons learned.

10.2 As appropriate the Committee will also be provided with:

• proposals for the terms of reference of internal audit / the internal audit charter;

• the internal audit strategy;

• the Head of Internal Audit's Annual Opinion and Report;

• quality assurance reports on the internal audit function;

• the draft accounts of the organisation;

- the draft Governance Statement;
- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on the Trust's approach to cyber-security, including updates on how cyber threats have been dealt with
- a report on co-operation between internal and external audit; and
- the organisation's Risk Management Strategy.

11 Frequency

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

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

12 Management

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

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

13 Financial Reporting

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

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

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

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

- Letters of representation
- Explanations for significant variances.

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

14 Committee Administration

14.1 The Trust Secretary shall provide secretarial support to the Committee;
14.2 Papers should be distributed to Committee members no less than five clear days before the meeting;

15. Review

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

Version Control

Version	Date	Author	Comments	Status
0.1	December 2008	James Bufford	Approved for Board by Audit Committee December 2008	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	Dec 09	Maria Wogan	Reviewed by Audit Committee – proposed amendments to the Board March 2010	For approval
1.2	March 10	Maria Wogan	Annual Review by the Board	Approved
2.0	Sept 2011	Geoff Stokes	Annual review by the Board	Approved
2.1	Jan 2012	Geoff Stokes	Add clinician to attendees list	
2.2	June 2012	Michelle Evans-Riches	Change to membership as Clinician cannot be a member	Approved
3.0	March 2013	Michelle Evans-Riches	Review by Audit Committee and Trust Board	Approved
4.0	Sep 2013	Michelle Evans-Riches	Annual Review	Approved
5.0	Sep 2014	Michelle Evans-Riches	Annual Review	Approved
6.0	Nov 2017	Adewale Kadiri	Annual Review	Approved
7.0	Oct 2018	Adewale Kadiri	Annual Review	Approved
8.0	Nov 2020	Julia Price	Annual Review by the Board	Approved
9.0	November 2021	Kwame Mensa-Bonsu	Annual Review by the Trust Board	Approved
10.0	November 2022	Kwame Mensa-Bonsu	Annua Review by the Trust Board	Approved
11,0	November 2023	Kwame Mensa-Bonsu		

Meeting Title	**Trust Board of Directors**	**Date: 02 November 2023**
Report Title	**Revised Terms of Reference – Charitable Funds Committee**	**Agenda Item Number: 25**
Lead Director	Kate Jarman, Director of Corporate Affairs	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	Assurance		
Key Messages to Note	No significant changes, apart from changes to the title of an Executive Director.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** x	**For Review** ☐

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

Report History	*Charitable Funds Committee, October 2023*
Next Steps	*Trust Board of Directors, November 2023*
Appendices/Attachments	*Revised Terms of Reference*

Milton Keynes University Hospital
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE

1. Constitution

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

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

2. Delegated Authority

2.1 The Committee has the following delegated authority:

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

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

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

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

3. Accountability

- The Charitable Funds Committee is a committee of the Trust Board. A minute of each meeting will be taken and approved by the subsequent meeting.

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

- The Chair of the Committee shall provide written reports to the Audit Committee, highlighting matters which provided information and assurance around risk management and internal control systems across the organisation.

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

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

4. Duties of the Charitable Funds Committee

The Charitable Funds Committee is charged by the Board to:

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

5. Membership, Attendance and Quorum

5.1 Membership

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

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

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

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

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

The Secretary of the Committee will be the Trust Secretary.

A meeting is deemed **quorate** when one Non-Executive Director, the named representative from the Finance Directorate and the named Governor from the Council of Governors are present.

6. Attendance

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

- Head of Charity
- A representative from the Finance Directorate
- Trust Secretary
- Invited representatives from the clinical directorates

7. Responsibilities of Members and Attendees

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

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

8. Meetings and Conduct of Business

8.1 Frequency

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

8.2 Calling Meetings

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

8.3 Agenda

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

Version Control

Version	Date	Author	Comments	Status
0.1	December 2008	Wayne Preston	Considered by Charitable Funds Committee and approved for Board	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	March 2010	Maria Wogan	Minor amendments recommended to Board 24.03.10	For approval
1.2	March 10	Maria Wogan	Annual Review by the Board	Approved
1.3	April 2012	Michelle Evans-Riches	Review of Committee Structure By Finance and Investment Committee	For approval
1.4	September 2012	Michelle Evans-Riches	Implement changes from Charitable Funds Committee 27 September 2012	For approval
2	August 2013	Michelle Evans-Riches	Annual Review and changes to Committee Structure	For approval
2.1	November 2013	Jonathan Dunk	Updated to reflect new charitable funds approval guidance	For approval
3	June 2014	Michelle Evans-Riches	Review following changes to Terms of Reference template	For approval
4	October 2017	Ade Kadiri	Annual Review	For approval
5	February 2019	Ade Kadiri	Annual review and changes to the procedure for bid applications	For approval
6	October 2019	Ade Kadiri	Annual review (continued) including replacement of the charitable order form	For approval
7	November 2020	Julia Price	Annual review by Trust board	Approved
8	Aug 2021	Kwame Mensa-Bonsu	Annual Review	Draft
8.1	27 Aug 2021	Haider Husain	Review & mark-up of draft	Draft
9	10 September 2021	Kwame Mensa-Bonsu	Review Completed	Draft
10	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
11	January 2023	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
12	November 2023	Kwame Mensa-Bonsu		

Meeting Title	**Trust Board of Directors**	**Date: 02 November 2023**
Report Title	**Revised Terms of Reference – Finance and investment Committee**	**Agenda Item Number: 25**
Lead Director	Kate Jarman, Director of Corporate Affairs	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	Assurance		
Key Messages to Note	Area reviewed and discussed by the Committee were: a. Purpose b. Quorum c. Duties		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** x	**For Review** ☐

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

Report History	*Finance and Investment Committee, September 2023*
Next Steps	*Trust Board of Directors, November 2023*
Appendices/Attachments	*Revised Terms of Reference*

Milton Keynes University Hospital
NHS Foundation Trust

Finance and Investment Committee
TERMS OF REFERENCE

1. CONSTITUTION

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

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

2. ACCOUNTABILITY

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

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

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

3. PURPOSE:

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

- the effectiveness and robustness of financial planning
- effectiveness and robustness of financial reporting
- the effectiveness and robustness of capital investment management
- the robustness of the Trust's cash investment strategy
- business case assessment and scrutiny (including ensuring that quality and safety considerations have been taken into account)
- the management of financial and business risk
- the capability and capacity of the finance function
- the administration, investments and financial systems relating to all charitable funds held by the Trust
- the effectiveness of the Trust's health informatics and information technology strategies and their implementation
- decisions for future investment in information technology

Commented [HL1]: The Committee wants reporting to be timely and accurate

- the effective implementation and management of the Trust's estates strategy, ensuring that this is in line with the Trust's overall strategy.

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

4. MEMBERSHIP, ATTENDANCE AND QUORUM

Membership

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

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

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

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

Attendance

The following should attend Finance and Investment Committee meetings:

- The Deputy Director of Finance
- Trust Secretary or nominated representative

Quorum

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

5. MEETINGS AND CONDUCT OF BUSINESS

Frequency

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

Calling of additional meetings

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

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

Committee Administration

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

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

Responsibilities of Members

Members of the Committee are expected to attend at least 75% of meetings. In the event that they identify any items for consideration by the Committee, these should be brought to the attention of the Chair at least 14 days before the meeting. Members must declare any conflicts of interest or potential conflicts of interest at the start of each meeting in accordance with the Trust's Conflicts of Interests Policy (even if such a declaration has previously been made).

6. DUTIES OF THE FINANCE AND INVESTMENT COMMITTEE

Financial Management

- To have oversight of the Trust's position and performance in the context of the BLMK ICS's performance.
- To ensure a comprehensive budgetary control framework that accords with guidance and legislation.
- To review financial plans and strategies and ensure they are consistent with the overall Trust Strategic Planning process.
- To approve budget setting timeframes and processes and recommend budgets to the Board of Directors.
- To monitor business performance against planned levels and hold to account for corrective action planning, including finance, activity, workforce, and capacity.
- To scrutinise and assess business cases.

Financial Reporting

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

Performance Management

- To review the potential or actual financial impact of operational performance against a defined set of indicators, such indicators to be subject to on-going review.

Business and Financial Risk

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

Value for Money and Efficiency

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

Capital Investment

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

Cash

- To act as the Investment Committee in line with approved Investment Policy.
- Ensure cash investments are monitored and give best returns.
- Ensure cash balances are robust, and continue to be so, on a 12-month rolling basis.

Technology

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

Estates

- To oversee the implementation and development of the Trust's estate strategy in line with the Trust's overall strategy.

7. RELATIONSHIP WITH AUDITORS AND AUDIT COMMITTEE

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

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

Audit

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

Annual Accounts

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

SFI's and SO's

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

Fraud

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

Version Control

Version	Date	Author	Comments	Status
0.1	5 January 2009	Wayne Preston	Approved for Board	Draft
1.0	January 2009	James Bufford	Approved by Board	Approved
1.1	11 Sept 2009	James Bufford	Added requirement for annual review of these terms of reference	Draft for Finance Cttee
1.2	March 2010	Maria Wogan	Additional amendments from Finance Director re: meeting frequency	Draft for approval by Board
1.3	March 10	Maria Wogan	Annual Review by the Board	Approved
2.0	Nov 2011	Geoff Stokes	Annual review by the Board	Approved
2.1	Aug 2012	Michelle Evans-Riches	Financial Reporting triggers included as appendix	Approved
3.0	Mar 2013	Michelle Evans-Riches	Review by Committee and Trust Board	Approved
4.0	Sep 2013	Michelle Evans-Riches	Annual Review	Draft for approval by Board
5.0	Oct 2013	Michelle Evans-Riches	Annual review by the Board	
6.0	March 2015			
7.0	October 2017	Ade Kadiri	Annual Review	Draft for approval by Board
8.0	October 2018	Ade Kadiri	Annual Review	Draft for approval by the Board
9.0	November 2020	Julia Price	Annual Review by the Board	Approved
10.	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
11	November 2022	Kwame Mensa-Bonsu	Annual Review by the Board	Approved

12	November 2023	Kwame Mensa-Bonsu		

Meeting Title	**Trust Board of Directors**	**Date: 02 November 2023**
Report Title	**Revised Terms of Reference - Quality and Clinical Risk Committee**	**Agenda Item Number: 25**
Lead Director	Kate Jarman, Director of Corporate Affairs	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	Assurance		
Key Messages to Note	No significant changes, apart from changes to the titles of Executive Directors.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** x	**For Review** ☐

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

Report History	*Quality and Clinical Risk Committee, September 2023*
Next Steps	*Trust Board of Directors, November 2023*
Appendices/Attachments	*Revised Terms of Reference*

Milton Keynes University Hospital NHS Foundation Trust

Quality and Clinical Risk Committee
TERMS OF REFERENCE

1. CONSTITUTION:

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

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

1.1 Authority

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

2. PURPOSE:

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

3. MEMBERSHIP, ATTENDANCE AND QUORUM:

3.1 Membership

The Membership of the QCRC shall be as follows:

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

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

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

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

3.2 Attendance

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

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

3.3 Quorum

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

4. ACCOUNTABILITY:

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

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

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

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

5. MEETINGS AND CONDUCT OF BUSINESS:

5.1 Frequency of Meetings:

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

5.2 Agenda

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

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

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

6. DUTIES OF THE QUALITY AND CLINICAL RISK COMMITTEE:

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

and is led by and involves staff from all disciplines, liaising with the Audit Committee as appropriate.

- To monitor compliance with the terms of the Trust's CQC registration and NHS Resolution Risk Management Standards.

Version Control

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

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board of Directors**	**Date: 02 November 2023**
Report Title	**Revised Terms of Reference – Workforce and Development Assurance Committee**	**Agenda Item Number: 25**
Lead Director	Kate Jarman, Chief of Corporate Services	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	Assurance		
Key Messages to Note	Please note the following for review: 1. Changes to titles 2. Revisions to the Trust officers who can be invited to meetings		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** x	**For Review** ☐

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

Report History	*N/A*
Next Steps	*N/A*
Appendices/Attachments	*Revised Terms of Reference*

Workforce and Development Assurance Committee
TERMS OF REFERENCE

1. Constitution

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

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

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

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

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

2. Delegated Authority

2.1. The Committee has the following delegated authority:

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

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

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

3. Accountability

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

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

4. Reporting Lines

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

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

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

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

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

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

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

5. Duties

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

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

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

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

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

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

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

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

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

5.9.1. Ensure all workforce indicators are measured and monitored;

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

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

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

6. Membership

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

6.2. The Committee will comprise the following members:

- Two other Non-Executive Directors
- Chief People Officer

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

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

7. Attendance

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

- Trust Board Chair
- Deputy Chief People Officer
- Assistant Director of HR – Education & OD
- Assistant Director of HR – Services & Systems
- Freedom to Speak Up Guardian
- Head of Employee Relations & Business Partnering
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7.2. Other Directors and Trust staff may be invited to attend at the discretion of the Chair.

8. Responsibilities of Members

8.1. Members of the Committee are required to

8.1.1. Attend at least 75% of meetings,

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

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

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

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

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

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

9. Frequency of Meetings

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

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

10. Committee Administration

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

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

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

11. Review

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

Version Control

Version	Date	Author	Comments	Status
1.0	Nov 2019	Adewale Kadiri Trust Secretary	Final draft approved by the Board of Directors	Approved
2.0	Nov 2020	Julia Price	Annual review by the Board	Approved
3.0	November 2021	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
4.0	November 2022	Kwame Mensa-Bonsu	Annual Review by the Board	Approved
5.0	September 2023	Kwame Mensa-Bonsu	Annual Review by the Board	

Meeting Title	**Trust Board Meeting in Public**	**Date: 02 November 2023**
Report Title	**Audit Committee Meeting Summary Report – 18 September 2023**	**Agenda Item Number: 26**
Chair	*Gary Marven, (Non-Executive Director)*	
Report Author	*Kwame Mensa-Bonsu, (Trust Secretary)*	

Key Messages to Note

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

The Committee reviewed its Terms of Reference, and subject to recommended changes being completed, recommended it to the Trust Board of Directors for ratification.

2. Items identified for escalation to Trust Board

a. The Committee focused on the increasing sophistication of mandate fraud, with the application of Artificial intelligence, and noted that there was the need for ongoing vigilance, and communication by the Trust.

b. Overpayments by payroll was a significant issue, and this was being caused by poor administrative processes. The Committee noted that this caused extra work for the Finance team and resulted in the Trust losing money.

c. Though waivers on procurements had declined by 18%, the Committee was significantly concerned that this was still above the pre-Covid level. There was the need for some focused action to further reduce the request of waivers on procurements.

d. The Committee noted the high level of violence and abuse on staff by patients and/their families and expressed the hope that though a complex issue to resolve, the Executives needed to continue communicating what was and was not acceptable to all stakeholders.

e. There was the need for a refreshed ADMK strategy.

3. Summary of matters considered at the meeting

a. The Committee reviewed and noted the External Audit Findings Improvement Action Plan.

b. The Committee reviewed the Internal Audit Action Tracking Status Report and noted the continued improvements 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.

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

d. The Committee reviewed the Financial Controller's Report and noted with concern, the high level of procurement waivers. This practice increased during the Covid pandemic but has continued after the return to normalcy post-pandemic.

e. The Committee received and reviewed the Third-Party Assurance Report. The report provided an overview of the third-party assurances received and reviewed in year from the external providers managing outsourced services for the Trust.

f. The Committee received the Health and Safety Report which highlighted the health, safety and welfare activity across the Trust from April 2023 to September 2023. The Committee noted with concern the high number of violence and abuse against over the period.

g. The Committee reviewed the 2022/23 Annual Report for its subsidiary, ADMK. There was a strong suggestion that the ADMK's strategy needed to be reviewed.

h. The Committee reviewed the Board Assurance Framework, and the Corporate and Strategic Risk Registers.

4. Highlights of Board Assurance Framework Review

None

5. Risks/concerns (Current or Emerging) identified

N/A

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

Meeting Title	**Trust Board Meeting in Public**	**Date: 02/11/2023**
Report Title	**Finance and Investment Committee Seminar Summary Report – 01/08/2023**	**Agenda Item Number: 26**
Chair	*Heidi Travis, (Non-Executive Director)*	
Report Author	*Kwame Mensa-Bonsu, (Trust Secretary)*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval a. The Finance & Investment Committee approved the request for additional funding for the Community Diagnostic Centre development project.
2. Items identified for escalation to Trust Board N/A
3. Summary of matters considered at the meeting a. The Committee received a presentation on the 2023/24 Capital Investment Programme which highlighted the current capital plan for 2023/24 and how it was being delivered. b. The Committee reviewed and noted the Performance Report for Month 03. c. The Committee reviewed and noted the Finance Report for Month 03. d. The Committee reviewed and noted the Capital Programme Expenditure Update for Month 03.
4. Highlights of Board Assurance Framework Review N/A
5. Risks/concerns (Current or Emerging) identified None. .

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

Meeting Title	**Trust Board Meeting in Public**	**Date: 02/11/2023**
Report Title	**Finance and Investment Committee Summary Report – 05/09/2023**	**Agenda Item Number: 26**
Chair	*Heidi Travis, (Non-Executive Director)*	
Report Author	*Kwame Mensa-Bonsu, (Trust Secretary)*	

Key Messages to Note

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

a. The Finance and Investment Committee approved the Haematology and Chemical Pathology – Service Contracts.

b. The Finance and Investment Committee approved the Ward 14 (Intermediate Care Ward) – Business Case.

c. Subject to some corrections being approved, the Committee recommended the revised Terms of Reference for approval by the Trust Board.

2. Items identified for escalation to Trust Board

a. Haematology and Chemical Pathology – Service Contracts.

b. Ward 14 (Intermediate Care Ward) – Business Case.

3. Summary of matters considered at the meeting

a. The Committee reviewed and noted the Performance Report for Month 04.

b. The Committee reviewed and noted the Finance Report for Month 04.

c. The Committee reviewed and noted the Capital Programme Expenditure Update for Month 04.

d. The Committee received a report on the 2023/24 Income and Expenditure Forecast for the Trust.

e. The Committee received an update around the Elective Recovery Fund, which had the aim of incentivising NHS providers to clear their elective backlog and increase the volume of planned care activity.

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.
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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: 02/11/2023**
Report Title	**Finance and Investment Committee Summary Report – 25/09/2023**	**Agenda Item Number: 26**
Chair	*Heidi Travis, (Non-Executive Director)*	
Report Author	*Kwame Mensa-Bonsu, (Trust Secretary)*	

Key Messages to Note
1. Matters approved by the Committee/Recommended for Trust Board approval a. The Finance and Investment Committee approved the Elective Care Self-Certification Process.
2. Items identified for escalation to Trust Board a. BLMK ICS's Medium-Term Financial position.
3. Summary of matters considered at the meeting a. The Committee reviewed and noted the Performance Report for Month 05. b. The Committee reviewed and noted the Finance Report for Month 05. c. The Committee reviewed and noted the Capital Programme Expenditure Update for Month 05. d. The Committee received a report on the progress of the Better Value (BV) Programme which outlined the planned actions to enhance financial and cost improvement and a review of non-recurrent schemes. e. The Committee received an update on the National Financial Performance, summarising the national financial position for July 2023. f. The Committee received a presentation on BLMK ICS's Medium-Term Financial position.
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*

Meeting Title	Trust Board Meeting In Public	**Date:** 02 November 2023
Report Title	Summary Report from the Trust Executive Committee Meeting held on 13 September 2023	**Agenda Item Number: 26**
Chair	Ian Reckless, Chief Medical Officer/Deputy Chief Executive	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Key Messages to Note

1. Matters approved by the Committee

a. The Trust Executive Committee recommended the Upgrade of Main Entrance Multistorey Car Park Top Deck Surface for approval when funding was identified.

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 brief spike of infections in relation to cardiac pacemakers, and how the event had been well managed the Cardiology team in conjunction with the Governance and Infection Prevention Control.

d. The Committee received the Risk Management Escalation report, which noted that the implementation of the Patient Safety Incident Response Framework (PSIRF) would significantly help in the management of the overdue incidents.

e. The Committee reviewed the Executive Director Update on Quality Improvement which focused on the improvement of internal processes for Clinical Audit.

f. The Committee reviewed and noted the Performance Report for Month 04.

g. The Committee reviewed and noted the Finance Report for Month 04.

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: 02 November 2023**
Report Title	**Use of Trust Seal**	**Agenda item: 27**
Lead Director	**Kate Jarman, Director of Corporate Services**	
Report Author	**Kwame Mensa-Bonsu, Trust Secretary**	

Introduction	Assurance & Compliance		
Key Messages to Note	• To inform the Board of the use of the Trust Seal. • That the Board of Directors note the use of the Trust Seal since July 2023		
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)*	*7. Spending money well on the care you receive* *8. Employ the best people to care for you* *9. Expanding and improving your environment* *10. Innovating and investing in the future of your hospital*

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

Use of Trust Seal

1. Purpose of the Report

In accordance with the Trust Constitution, this report informs the Board of entries in the Trust seal register which have occurred since the last full meeting of the Board.

2. Context

Since the last Trust Board, the Trust Seal has been executed as follows:

i. 20 September 2023 – Lease relating to Lloyd Cout

ii. 20 September 2023 – Licence to carry out work at Lloyds Court

iii. 16 October 2023 – £5.7m Grant agreement between the Milton Keynes Council and MKUH towards the Radiotherapy Centre Construction.

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
	CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off
	Progress update – 2023/24 Quality Priorities
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)
	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