Bundle Trust Board Meeting in Public 11 January 2024

1.1 10:00 - Agenda
Chair
1. Agenda Board Meeting in Public - 11.01.24 v 4

1.2 10:01 - Apologies

2 10:02 - Declarations of Interest
Chair

3 10:03 - Patient Story
Chief Nursing Officer
3. Trolley and clothing project presentation for Board January

4 10:23 - Minutes of the Last Meeting
Chair
4. DRAFT Minutes Trust Board Meeting in Public 02.11.23

5 10:26 - Matters Arising and Action Log
Chair
5. Board Action Log 02.11.23
5.1 Extention To A Non-Executive Director Tenure For A Final 3 Year Re Heidi Travis

6 10:31 - Chair's report
Chair

7 10:36 - Chief Executive's Report
Chief Executive
7c. MKUH 11 January 2024 FINAL

8 10:41 - Serious Incident and Learning Report
Chief Medical Officer
9. SI report for Trust Board January 2024 final

9 10:46 - Maternity Assurance Group Update
Chief Nursing Officer
9. MKUH Dec 2023 Nov-Dec MAG Coversheet YC
9a. MAG Minutes 26.10.2023
9b. MAG Minutes 23.11.2023

10 10:51 - Establishment Reviews
Chief Nursing Officer
11a. Safe Staffing and Establishment Review Nov23
11b. Bi-Annual Nursing Midwifery and Allied Health report November 2023 V3 YC

11 10:58 - CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off

Chief Nursing Officer

12. CNST board paper 2024
12a. CNST Trust Board Presentation EG (003)
12b. MKUHMIS_SafetyAction_2024_V12
12c. MISyear5-update-July-2023 (2)

12 11:05 - Performance Report
Chief Operating Officer

13. 2023-24 Executive Summary M08 Coversheet
13.1 2023-24 Executive Summary M08
13.2 M08 Board Performance Report - Objective O
13.3 M08 Board Performance Report - Objective 1
13.4 M08 Board Performance Report - Objective 2
13.5 M08 Board Performance Report - Objective 3
13.6 M08 Board Performance Report - Objective 4
13.7 M08 Board Performance Report - Objective 5
13.8 M08 Board Performance Report - Objective 7
13.9 M08 Board Performance Report - Objective 8

13 11:12 - Finance Report
Interim Chief Finance Officer

14. Public Finance Report Month 8

14 11:22 - Workforce Report
Chief People Officer

15. Workforce Report M8 2023 Board

15 11:27 - Risk Register Report
Chief Corporate Services Officer

16. Trust Board - January 2024 - Risk Register Report
16a. Corporate Risk Register - as at 3rd January 2024
16b. Significant Risk Register - as at 3rd January 2024

16 11:32 - Board Assurance Framework
Chief Corporate Services Officer

17. Board Assurance Framework Jan 24

17 11:37 - Forward Agenda Planner
Chair

18. Trust Board Meeting In Public Forward Agenda Planner

18 11:42 - Questions from Members of the Public
Chair

Chair

20 11:52 - 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."

21 11:56 - Close
Next Meeting in Public: Thursday, 08 February 2024

Agenda for the Board of Directors' Meeting in Public

Meeting to be held at 10:00 am on Thursday 11 January 2024
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 • 2024/25 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	Attached
4		Minutes of the Trust Board meeting held in public on 02 November 2023	Approve	Chair	Attached
5		Matters Arising and Action Log • Non-Executive Director extension to tenure for a final 3 years – Heidi Travis	Note	Chair	Attached Attached
Chair and Chief Executive Updates					
6	10:20	Chair's Report	Information	Chair	To Follow
7	10:25	Chief Executive's Report a. Update on commissioned pieces of work b. Staff access to NHS Services	Receive and Discuss	Chief Executive	Verbal

Item No.	Timing	Title	Purpose	Lead	Paper
		c. BLMK ICB December 2023			Attached
Patient Safety					
8	10:35	Serious Incident and Learning Report	Receive and Discuss	Chief Medical Officer	Attached
9	10:40	Maternity Assurance Group Update	Receive and Discuss	Chief Nursing Officer	Attached
10	10:55	Establishment Reviews	Receive and Discuss	Chief Nursing Officer	Attached
11	11:10	CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off	Receive and Discuss	Chief Nursing Officer	Attached
Performance					
12	11:15	Performance Report 08	Receive and Discuss	Chief Operating Officer	Attached
Finance					
13	11:25	Finance Report 08	Receive and Discuss	Interim Chief Finance Officer	Attached
Workforce					
14	11:35	Workforce Report 08	Receive and Discuss	Chief People Officer	Attached
Assurance and Statutory Items					
15	11:40	Risk Register Report	Receive and Discuss	Chief Corporate Services Officer	Attached
16	11:45	Board Assurance Framework	Receive and Discuss	Chief Corporate Services Officer	Attached
Administration and Closing					
17	11:50	Forward Agenda Planner	Information	Chair	Attached
18		Questions from Members of the Public	Receive and Respond	Chair	Verbal
19		Motion To Close The Meeting	Receive	Chair	Verbal
20		Resolution to Exclude the Press and Public	Approve	Chair	

Item No.	Timing	Title	Purpose	Lead	Paper
		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.”			
12:00		Close			
Next Meeting in Public: Thursday, 08 February 2024					

Milton Keynes University Hospital
NHS Foundation Trust

Improving Patient Experience

Julie Goodman, Head of Patient and Family Experience
Lisa Barnes, Patient Experience Lead
January 2024

TheMKWay

Buddy –
The Patient Experience
Trolley

Milton Keynes University Hospital NHS Foundation Trust

- Aim - to provide patients with information/personal items/activities to support experience - as feedback demonstrated there was a need for this (this is an add on to the QR code project)
- We asked patients - 'What small, but significant items/resources do you feel would make patients feel welcome and cared for?'
- Competition held to name the trolley and 'Buddy' chosen by the CNO
- Buddy is taken to ward areas, identified as needing support, by volunteers with support from the Patient and Family Experience team
- Initiates a discussion with patients and their families to gain feedback on their experience
- If needed, Buddy provides personal care items, activities etc. Supported by the hospital charity from monies raised by the Patient and Family Experience team

Milton Keynes University Hospital NHS Foundation Trust

Trolley showcased in Milton Keynes Community Hub

MKUH Introduces New Patient Experience Trolley

This week saw the introduction of a new patient experience trolley. Made possible by donations to Milton Keynes Hospital Charity, Buddy the Trolley had its first outing, wheeled around Wards 1 and 14 by Patient Experience Co-ordinator Sharon White and our new volunteer, Hyacinth (pictured).

The trolley was very well received by both staff and patients, containing items to make our patients' stay as comfortable as possible, including toiletries, arts and crafts and other activities, patient and visitor information, and even greetings cards so patients can send well wishes to loved ones whilst in hospital.

The trolley gives the Patient and Family Engagement Team an opportunity to spend time with and chat to patients, collecting vital feedback to ensure we provide the best possible care.

Julie Goodman, Head of Patient and Family Experience, said: "I was very proud to see this project come to fruition this week. 'Buddy' has been developed with the help of feedback from our patients, their families, and staff and contains a wide range of activities, information and products aimed at enhancing the experience of our patients.

In the coming weeks and months our aim, with the help of our volunteers, is to ensure that Buddy makes an appearance on the wards every day, Monday to Friday, allowing us to help as many patients as possible."

Milton Keynes University Hospital NHS Foundation Trust

Developments

- Volunteers and recruitment is ongoing
- First ward visit took place on the 18th January 2023
- Buddy visits wards up to three times a week
- Visit short stay wards regularly and then other wards, whenever possible
- FFT forms also given out to each patient visited, increasing feedback
- New items being added as suggested by patient
- Charity providing ongoing funds and have promotional material on the trolley

Milton Keynes Hospital Charity

Feedback Received

Milton Keynes University Hospital NHS Foundation Trust

Staff

'I really enjoyed taking Buddy out to patients and being able to supply the simple things which made a massive difference to the patients. To see this providing such a positive experience made me very proud. It is a great idea with lots of useful things you might need whilst in hospital. The patients were pleased and really appreciated the idea and many made use of it.'

'Your visit to Ward 7 made a few hearts happy and joyful. Thank you very much for all the thoughtful little things you do. Appreciate all PE team. Can I please request for a few disposable paper knickers and ear plugs for Ward 7?'

Patients

'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.'

'Room lovely clean, nurses lovely, the trolley with the free stuff was amazing.'

'Energy back, felt so depressed. Now I am able to do what I would do at home, wash, clean my teeth and feel human again.'

'Rather sceptical at first but once I tried the water painting I have been converted. Amazing.'

Volunteers

Safiyyah - I enjoy taking the trolley out because it helps quite a number of patients and puts a smile on their faces which just makes my day.
I think it all boils down to that sense of self satisfaction I get by just providing a free service to help someone in need of the little things which many of us take for granted until we don't have them with us.
As for patient feedback - they all simply love it. I haven't come across anyone who has gotten annoyed or frowned upon the idea of the trolley.
The patients appreciate the service and always tell us that it's such a good idea.

Moria – I help with the trolley because of my stroke. I spent some time in MKUH and lost my memory. I wanted to give something back to the NHS, say thank you and help.
I love taking the trolley out as I get to go on wards and chat to patients. I have a real laugh with some of them. I can relate to some of the patients and share my story with them. Really helps me too
The patients are very grateful for the trolley as they can come in with nothing with them. They are amazed when they don't have to pay.

TheMKWay

Clothing Project

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

How dignified would you feel walking around or going home in a gown?

- **A result of feedback from Age UK, complaints, and discussions at the PFEB.**
- **Aim - to ensure that there is an adequate supply of clothing and footwear for those patients who do not have their own clothes for discharge**
- **Highlights the significance of dignity in the care provided,**

how we can prevent de-conditioning during admission and how we can prepare patients for discharge.

Why is was needed

Quotes from complaints

Milton Keynes University Hospital NHS Foundation Trust

'At about 12.45 hours my drain tube was removed and at 13.00 hours there was another sudden burst of activity. In what seemed like seconds, all of my belongings were moved from my locker, side table etc into bags which were placed on my bed which was by now completely stripped. The fact that I had no clothes on seemed to be of no interest. I did find a pair of shorts and with hospital gowns on front and rear I was whisked off to the Discharge Lounge.'

'As I was bleeding a lot and I thought I was going to die I didn't bring my bag with me in the ambulance. I only had the baby's bag. I left the hospital in a bed sheet, wrapped in a bed sheet- there was no offer of a gown or any other clothes.'

'Just as we had established he was not going home an ambulance arrived at my Mum's house, with Dad still in his hospital pyjamas! Dark rainy night and the ambulance crew said they'd had issues all day with discharges.'

'My mother was brought home from hospital in freezing cold conditions with pneumonia wearing a hospital nightdress which was open at the back, with a cardigan on top, she had bare legs and velcro shoes on, she was delirious, had a temperature and was deeply distressed'

'When I drove and collected my father he was in the blood-stained hospital gown with a towelling gown and no coat and no shoes on his feet. I could not believe the manner in which I collected him. It was heartbreaking. He didn't even have underwear or trousers.'

'The patient was received in the mortuary covered in a sheet but was naked underneath. All patients when sent to the mortuary need to be dressed. This can be a shroud, hospital gown or in the patient's own clothes. This is to maintain the dignity for the patient.'

Continuing….

Milton Keynes University Hospital NHS Foundation Trust

- Collaborative project with the Patient and Family Experience team,Charity, Frailty team, Age UK and Voluntary Services.
- Contact made via the charity for a supplier and events held to raise money to ensure supply is ongoing. Clothes also donated by members of the public and through contacts with the Chaplaincy team
- Voluntary services purchased two linen trolleys for the project. Also have smaller boxes for each ward with instructions on how clothes can be obtained
- Recruitment of Patient Clothes Bank Volunteers to manage the supply
- Two sales held - raised over £600 for the project - his will be ongoing
- Patients and staff very grateful and positive
- Support the Frailty team at education events, such as the Frailty festival
  - "Put dignity top of the list not the bottom" #endpjparalysis #last1000days - Get up get dressed get moving.
- Work ongoing to collect feedback from staff, patients and families
- **Support needed with storage of the two linen trolleys. Needs 24/7 access**

#EndPJparalysis GET UP, GET DRESSED, GET MOVING

Project in action

Milton Keynes University Hospital NHS Foundation Trust

PATIENT STORY
Vulnerable young lady on Ward 20 arrived from supported living late at night in her pjs. Nothing with her and no one to bring anything in for her. Wanted to go home and was using the bus. Given entire outfit with shoes so she could be discharged in a dignified manner. Ward staff also very grateful.

PATIENT STORY
Contacted by fundraising as there was a patient sitting in the chapel with no shoes. He was not local. Given a new pair of shoes to support whilst on the ward and to get back home. He was very touched.

TheMKWay

Thank you!

Milton Keynes University Hospital NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 02 November 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)
Dev Ahuja	Non-Executive Director	
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)
Andrea Vincent	Public Governor	(AV)
Andy Forbes	Public Governor	(AF)
Ken Rowe	Public Governor	(KR)
Tom Daffurn	Public Governor	(TD)
Jason Sinclair	Associate Non-Executive Director	(JS)
Ganesh Baliah	Associate Non-Executive Director	(GB)
Precious Zumbika-Lwanga	Associate Non-Executive Director	(PZL)
Keith Mclean	Representative Governor, Milton Keynes Council	(KM)
Nicholas Mann	Business Leaders Representative	(NM)
Lynn Wren (Item 3)	Deputy Head of Research and Development	(LW)
Sharon Robertson (Item 3)	Matron for Patient & Family Experience	(SR)
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 Mark Versallion (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 LW and who presented a Research and Development participant story relating to Children's Radius Acute Fracture Fixation Trial (CRAFFT) - a multi-centre prospective randomised non-inferiority trial of surgical reduction versus non-surgical casting for displaced distal radius fractures in children between the ages of 4 to 10 years old.

3.2 "*Sam*" was a 10-year-old boy who fell onto his outstretched arm whilst playing football at school and presented to the Paediatric Emergency Department (ED). He was identified as a candidate for CRAFFT by the Orthopaedic team and information around the study was provided and consent received from his relative.

3.3 Initially, there was some concern that Sam's fracture was too close to its growth plate, however, it was discussed that since he fit the CRAFFT study's inclusion requirements, the family should be involved in the decision-making process. "*Sam's"* family was informed that the research was voluntary and provided with a balanced perspective between surgery and CRAFFT. "*Sam"* had a nonoperative procedure, his cast was changed, and he was discharged back home.

3.4 The outcome including Sam in CRAFFT was that there was reduced hospital stay and bed occupancy which had a potential saving of £1,600 for the Trust as there was no need for an operative procedure and the patient and his family were pleased that they were included in the decision about the patient's care.

3.5 This research encouraged shared decision making and offered patients and their relatives' greater control over their own health and care.

3.6 On behalf of the Board, AD thanked LW for the presentation.

4 Minutes of the Trust Board Meeting in Public held on 07 September 2023

4.1 The minutes of the Trust Board Meeting in Public held on 07 September 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 Review of the Significant Risk Register
An overview of the Trust's risk position and risk appetite had been included in the Risk Register Report. Completed.

There were no other matters arising.

6 Chair's Report

6.1 AD provided an update from events held during the Black History Month and Freedom to Speak Up (FTSU) Month in October 2023. She advised that events included encouraging members of staff to make FTSU pledges, celebrating Diversity Event in the Tent and online presentations and discussions with Inspiring Women.

6.2 AD provided feedback following her attendance at the Integrated Care Partnership meeting in October 2023. She advised of the discussion around the Trust's initiatives, Mental Health services and the reduction of assistance from the police force in times of crisis.

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

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

7.1 JH began his report by thanking the BAME team for organising a series of successful events during the Black History Month in October 2023.

7.2 JH stated that the staff survey had launched 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.

7.3 External Reviews and Support - Organisational and Board Culture
JH advised the Board of the External Reviews and Support which were being commissioned. These included an organisational culture development programme which would be led by an independent external expert focused on anti-racism/tackling racism and racial inequality in the Trust, an external review of Human Resources, an external review of Board papers and support from the Care Quality Commission who would be working with the Trust to explore the lived experience of Black, Asian and Minority Ethnic members of staff and review Workforce Race Equality Standard (WRES) data and reports.

BLMK Health and Care Partnership and Integrated Care Board September 2023 Update
The Board noted the BLMK Health and Care Partnership and Integrated Care Board September 2023 Update and there were no questions raised in terms of the agenda item.

The Denny Review: A review of health inequalities in Bedfordshire, Luton and Milton Keynes
The Board noted The Denny Review: A review of health inequalities in Bedfordshire, Luton and Milton Keynes and there were no questions raised in terms of the agenda item.

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

8 Serious Incident and Learning Report

8.1 IR presented the Serious Incident and Learning Report asking the Board to note SIs 2023/17751 (Overdose Incident) and 2023/18362 (Gentamicin administration error), the safety measures that had been put in place and the ongoing work with staff around reducing the inherent risks around these incidents.

8.2 KJ reported that the Health and Safety Executive would be inspecting the Trust for a week in January 2024, with a focused inspection on action taken to prevent violence and aggression and managing musculoskeletal disorders in the Trust.

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

9 Mortality Update

9.1 IR presented the Mortality Update Report.

9.2 IR reported that there were no significant outlier areas of concern and there was quantitative data to show that the risk-adjusted mortality at the Trust was "as expected" when compared to peers.

9.3 IR advised that the Trust had conducted extensive research to understand its position in relation to the risk-adjusted mortality indices Hospital Standardised Mortality Ratios (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) as some of the figures were numerically above the national average. The review key findings included the frequency with which 'signs or symptoms' were coded as the primary diagnosis at the Trust as this had increased since the introduction of our Electronic Health Record (EHR) and the proportion of in-hospital SHMI-spells with invalid or incomplete primary diagnosis.

9.4 The Board **noted** the Mortality Update

10 Maternity Assurance Group Update

10.1 YC presented the Maternity Assurance Group (MAG) Update report and highlighted three key areas as part of her overall report:

1. Birth Forecast and Capacity – MAG discussed the increase of maternity bookings and births in comparison to 2022, which demonstrated an increase of bookings by 14% and a 9.7% increase in births. Further statistical analysis was being conducted to manage any increased acuity proactively. Workforce plans were also being developed to manage any increase in demand.

2. Midwifery Workforce – A Business Case had been submitted for the uplift for 6 additional registered midwives which brought the department in line with '*birth rate plus'.*
3. NHS England (East Region) had reviewed the 2022 Office for National Statistics (ONS) data concerning stillbirths and noted an increase in Bedfordshire, Luton, and Milton Keynes (BLMK). A thematic review of BLMK stillbirths had commenced for 2022 led by the Local maternity and neonatal system (LMNS). As part of this work, the Trust had initiated a thematic review and expected to report any findings at MAG in November 2023.

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

11 Safeguarding Annual Report

11.1 YC presented the Safeguarding Annual Report summarising the Trust's Safeguarding activities from April 2022 to March 2023.

11.2 YC highlighted the increased activity and complexity of Adult and Child Safeguarding cases in the Trust and stated that the key area of focus was providing support and appropriate care facilities for Children and Young People with Mental Health problems in the Emergency Department (ED).

11.3 KJ emphasised the challenges and risks to staff due to the National changes pertaining to the withdrawal of the Police providing support related to Mental Health crisis. She stressed the significance of having an ongoing plan in place to manage Mental Health incidents as there were risks to other patients as well.

11.6 The Board **noted** the Safeguarding Annual Report

12 Annual Complaints Report

12.1 KJ reported that the Trust received 1044 complaints (both formal and informal) during 2021/22, a 25.5% increase over 2020/21. She stated that efforts were continuing to improve how complaints were evaluated and responded to in a timely manner.

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

13 Annual Patient Experience Report

13.1 KJ provided an overview of patient experience, engagement and feedback across the Trust and actions taken to improve patient and family experience. She stated that the Patient Experience team were working towards providing the SignLive service for patients that use BSL on demand interpreting service. This online video service would be accessible via iPads on mobile stands. The hospital Charity had donated 10 iPads for this project which could be used in various locations throughout the Trust. The project was ongoing with the involvement of the Communications team and the IT department.

13.2 The Board **noted** the Annual Patient Experience Report

14 Performance Report Month 06 (September 2023)

14.1 EL presented the Performance Report for Month 06. She reported that from an (Emergency Department) ED perspective, there was a slight increase of 654 attendances when compared to August 2023. She stated that the percentage of admissions, transfers, or discharges within 4 hours was 70.0%, a 3.7% decrease when compared to August 2023 and that although this was lower than the National average of 71.6%, it was higher than all but one other Trust when compared with peers.

14.2 In September 2023, overnight bed occupancy was 88.2%, which was within the targeted 92% threshold, and non-urgent elective activity and treatment for patients on an incomplete RTT pathway were being proactively managed.

14.3 The Board **noted** the Performance Report for Month 06

15 GIRFT Elective Update

15.1 The Board **noted** the GIRFT Elective Update

16 Finance Report 06

16.1 TW reported a £4.1m deficit 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 had been driven by a recognition of £3.2m of Elective Recovery Fund (ERF) over-performance as per NHS England (NHSE) guidance.

16.2 In terms of financial affordability, the Trust continued to face challenges around the impact of industrial action, vacancies, and supernumerary nursing arrangements. However, the run-rate was improving as actions to reduce cost pressures took effect.

16.3 The Trust's savings target for the year was £17m (4.8% of expenditure), £7.3m was reported to September 2023 representing a significant improvement on last month's total of 5.2m. Progress had been made during September with a risk adjusted position of £16.4m.

16.4 The Board **noted** the Finance Report for Month 06 (September 2023).

17 Workforce Report 06

17.1 DP highlighted the following from the report.

1. Temporary staffing usage continued to reduce at 13.5% which was a 1.8% improvement in cost from the beginning of the financial year. 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. Recruitment continued to improve with 4278 employees in post and a slight decrease in staff absences in Month 06 (September 2023).
3. Statutory and mandatory training compliance was at 95% and appraisals compliance was 90%. Medicine, Surgery and Corporate Services had dipped below the appraisal compliance Key Performance Indicator (KPI) in M06. Assurance and action plans for recovery had been requested from the Divisions.
4. Staff appreciation week ran in the first week in October 2023 and goody boxes filled with fruit and sweet and savoury treats were distributed to Wards and Departments to say thank you to staff for their hard work.
5. The '*Appraise with Values'* toolkit and new appraisal paperwork was starting consultation in M08 (November 2023) with planned implementation in Q4. Engagement had begun with Clinical staff to ensure the appraisal paperwork was easier to complete and that managers were more effective at giving feedback and identifying support for progression.
6. The Workforce team were launching 'Courageous Conversations' training for Managers in M08 (November 2023) to support them in how to respond effectively to team members that wish to raise a concern. The focus would be on how to listen actively, respond, and act in order to improve the listening culture of the organisation.

17.2 The Board **noted** the Workforce Report for Month 06 (September 2023).

18 **Freedom to Speak Up** (FTSU)

18.1 DP reported that there had been an increment in Freedom to Speak Up referrals with 66 new concerns raised to the FTSU Team. Referral themes were around intolerance of poor behaviours with most cases where the witness had asked for support and intervention from the Guardian being dealt with through FTSU intervention with line managers or support from the Human Resources teams.

18.2 The FTSU team had trained and recruited more Champions and plans were being developed for further Champion training dates with areas such as the Paediatrics and Neonatal teams.

18.3 The Board **noted** the Freedom to Speak Up (FTSU) Update

19 2022/23 Annual Infection Prevention and Control Report

19.1 IR presented the 2022/23 Annual Infection Prevention and Control Report and highlighted the surgical site infection surveillance which had continued within the knee and hip categories, and caesarean section deliveries.

19.2 The Trust recorded 19 cases of Clostridioides difficile across the 2022/23, 5 more than the previous year. IR stated that the number of cases arising in the Community was also higher than the previous year (37 in 2022/23 compared to 24 2021/22). The reasons for this were not well understood.

19.3 The Board **noted** the Infection Prevention and Control Report 2022/23 Annual Report.

20 Research & Development Annual Report

20.1 The Board **noted** the Research & Development Annual Report

21 Guardian of Safe Working Hours Annual Report (2022 - 2023)

21.1 IR presented the 2022/23 Guardian of Safe Working Hours Annual Report and provided an overview of the ongoing application of contractual requirements introduced in the new issue of Terms and Conditions of Service for NHS Doctors and Dentists in Training, 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.

21.2 IR stated that there had been a rising trend in exception reports in last 2 years, which was positive and suggested that trainee Doctors were aware of the exception reporting system and used it to raise any issues related to work, education, and staffing.

21.3 The Board **noted** the 2022/23 Guardian of Safe Working Hours Annual Report

22 Risk Register Report

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

23 Board Assurance Framework

23.1 The Board **noted** the Board Assurance Framework

24 Update to the Terms of Reference of the Board and its Committees

24.1 **Board of Directors**

The Board **reviewed** and **approved** the revised Terms of Reference for the Board of Directors

24.2 **Audit Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Audit Committee.

24.3 **Charitable Funds Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Charitable Funds Committee.

24.4 **Finance and investment Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Finance and Investment Committee.

24.5 **Quality and Clinical Risk Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Quality and Clinical Risk Committee.

24.6 **Workforce and Development Assurance Committee**

The Board **reviewed** and **approved** the revised Terms of Reference for the Workforce and Development Assurance Committee.

25 Board Committees Summary Reports

25.1.1 **Summary Report for the Audit Committee – 18 September 2023**

The Board **noted** the report.

25.1.2 **Summary Report for the Finance and Investment Committee Meeting – 01 August 2023, 05 September, and 25 September 2023.**

The Board **noted** the report.

25.1.3 **Summary Report for the Trust Executive Committee – 13 September 2023**

The Board **noted** the report.

26 Use of Trust Seal

26.1 The Board **noted** the Use of Trust Seal.

27 Forward Agenda Planner

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

28 Questions from Members of the Public

28.1 There were no questions from the public.

29 Any Other Business

29.1 JH announced that it was TW's last attendance at the Board meeting as he moved on to another role in a different organisation and advised that DT would be acting up as an Interim Chief Finance Office before the appointed Chief Finance Officer began his role. The Board thanked TW for all his hard work whilst at the Trust.

29.2 KJ announced that KMB was leaving the Trust to take on an Executive role in another organisation. The Board thanked KMB for all his hard work whilst at the Trust and wished him well in his new role.

29.2 The meeting closed at 13:17pm

Updated : 02/11/23

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	02-Nov-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.	**Completed**
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**

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: January 2023**
Report Title	**Non-Executive Director extension to tenure for a final three years**	**Agenda Item Number: 5**
Lead Director	Alison Davis, Chair	
Report Author	Kwame Mensa-Bonsu, Trust Secretary	

Introduction	N/A		
Key Messages to Note	To seek the approval for a recommendation from the Council of Governors' (CoG) Non-Executive Director (NED) Appointments Committee, after its meeting on 08 December 2023, to re-appoint Heidi Travis as a Non-Executive Director at the end of her current term of office for a further and final three-year term of office.		
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	Non-Executive Director (NED) Appointments Committee, December 2023
Next Steps	N/A
Appendices/Attachments	1. Report

1. Introduction and Background

The Council of Governors' Non-Executive Director (NED) Appointments Committee is constituted as a standing committee of the Council of Governors. It is the responsibility of the Committee to advise the Council of Governors in respect of the re-appointment of any NED in relation to any term including beyond six years.

By convention and practice, the Trust's NEDs have served only two terms in office amounting to a maximum of six years. Heidi Travis was appointed on 01 March 2018, and in line with that convention and practice, was scheduled to retire from the Trust Board of Directors on 29 February 2024.

However, NHS Foundation Trusts are permitted under the 2023 Code of Governance for NHS Provider Trusts to extend terms beyond six years, with a clear rationale as to why that action is being taken.

2. Rationale

Heidi Travis, as the experienced Deputy Chair/Senior Independent Director, is the longest serving NED and the rationale for seeking approval for re-appointment to a final three-year term of office are as follows:

a. Heidi has throughout her tenure effectively contributed with sound advice to many aspects of the Trust Board's activities and discussions. As such, as there has been a significant but unavoidable NED turnover since 2022/23, it is important that steps are taken to ensure Heidi is retained on the Trust Board while the new NED cohort settle in their roles.

b. Re-appointing Heidi will provide the Board Chair with the space to develop and prepare the newer NEDs to succeed to the very important role of Deputy Chair/Senior Independent Director.

c. As the long-serving Chair of the Trust Board's Finance and Investment Committee, it is important that Heidi is retained while the newly appointed Chief Financial Officer takes up their role in February 2024.

d. The experienced support of Heidi will be crucial in 2024 when two new NEDs, as well as a new Trust Secretary, will be appointed. The retirement of Heidi will require the appointment of a third new NED during a period when her retained experience will rather be important while significant external reviews have been commissioned.

e. In November 2023, the Chief Executive began the process of commissioning external reviews in several areas with the aim of strengthening the cultural outlook of both the Board and Trust as a whole. These important reviews will review matters regarding racism and racial equality, the Trust's HR frameworks and the Trust Board's governance. Heidi's extensive knowledge and experience will be

crucial in helping ensure any recommendations from the external reviews are fully and successfully implemented.

3. Procedural Guidance on Reviewing and Approving the Re-Appointment Request

Paragraph 4.3, Chapter 4, Section C of the 2023 Code of Governance for NHS Provider Trusts states that:

"……NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time……. The need for all extensions should be clearly explained and should have been agreed with NHS England".

The following should please be noted:

a. That the retention of Heidi will most certainly facilitate effective succession planning and progress with the development of a diverse Trust Board.

b. Subject to approval by the Council of Governors, Heidi will be re-appointed to a single three-year term only. There will be no further extension and the terms and conditions of the re-appointment will be clearly set out in the Letter of Re-appointment.

c. Approval by the Council of Governors will be subject to NHS England also approving the re-appointment.

d. If approved, the rationale for the re-appointment will be reported in the Trust's 2023/24 Annual Report and Accounts.

4. Recommendation

The Council of Governors is asked to approve the recommendation from the NED Appointments Committee to re-appoint Heidi Travis, Non- Executive Director, for a single and final three-year term of office from 01 March 2024.

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date 11 January 2024

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

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

BLMK Health and Care Partnership Member: Alison Davis, Chair Milton Keynes University Hospital NHS Foundation Trust

Report Author: Geoff Stokes, Interim Programme Director – Governance, Bedfordshire, Luton and Milton Keynes (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 and BLMK Health and Care Partnership that are relevant to Milton Keynes University Hospital NHS Foundation Trust.

2.0 Recommendations

2.1 The Board is asked to **note** this report and provide feedback to the ICB to help develop routine two-way reporting from the ICB and Health and Care Partnership to the Board in the future.

2.2 The Board is asked to note the proposed approach to the annual review of the Joint Forward Plan (JFP) and the assumption that no significant changes are anticipated for 24/25 due to the JFP being agreed by partners in June 2023. The JFP will be updated to align with 2024/25 operational, financial and workforce planning returns, and these are being developed with partners.

2.3 The Trust Board is asked to **authorise** the Trust Chair and CEO to agree any significant amendments to the JFP if required and if it is not possible to bring any amendments to a formal Trust Board meeting for approval due to timing issues.

2.4 The Board is asked to **note** the changes underway to strengthen system risk management including the further development of a system risk register.

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 Health and Care Partnership. Each individual report considered at those meetings identifies the relevant implications as listed above.

4.0 Report

4.1 Bedfordshire, Luton and Milton Keynes Integrated Care Board – Public Meeting

The Board of the ICB met on 8 December 2023 and a summary from the meeting is given below. The following items were discussed.

Resident's story – Importance of a Personalised Approach
Members watched a video from Roxy, a resident from Milton Keynes who attended the Board meeting in March to share how back pain has affected her life. She returned to the Board to provide an update on her condition and how her insight is shaping service delivery. The ICB's Chief Nurse, Sarah Stanley, explained how the ICB has worked with Roxy to inform how personalised care and treating the person, rather than the symptom, provides a more positive outcome and experience. These lessons are being factored into the procurement process for musculoskeletal (MSK) services across BLMK.

Joint Forward Plan (JFP)
It was agreed that as the BLMK Joint Forward Plan (which sets out our direction of travel to 2040) was agreed in June 2023, and remains aligned to our strategic priorities and those of the Health and Wellbeing Boards, BLMK partner NHS trusts and Health and Wellbeing Boards should be advised that the ICB does not anticipate that our annual review of the JFP will require the ICB to make any substantive changes to the JFP for 2024/25.

As part of the annual NHS planning process for 2024/25, work is underway with colleagues from local authorities and NHS trusts to prepare NHS financial, workforce and activity plans for next year. We will reflect the outcome of this work as appropriate in an updated JFP and, should the ICB consider that any significant changes to the JFP are necessary, we will let partners know and seek approval for these, depending on timing, this may need to be outside formal Board meetings.

The Trust Board is asked to **note** the proposed approach to the annual review of the Joint Forward Plan (JFP) as described above and **authorise** the Trust Chair and CEO to agree any significant amendments to the JFP if it is not possible to bring any amendments to a formal meeting for approval due to timing issues.

System response to the Denny Review of Health Inequalities
Following publication of the Denny Review in September, the Board was asked to agree a system wide response to the Denny Review, which included nine key

recommendations. Members welcomed the report, agreed to formally thank Reverend Lloyd Denny for the review, and confirmed their commitment to supporting a generational change in BLMK.

They approved all nine recommendations, including the appointment of Lorraine Sunduza, Chief Executive of East London Foundation Trust (ELFT), as the Board level Champion for this work. It was noted that all partners have agreed to consider the application of the Review's recommendations to their own organisations and to participate in system-wide improvement activity accordingly.

The Board supported the decision to explore the development of a system wide translation service, commit to an annual update for three years and to hold a board seminar event in spring 2024.

Delivering integrated Primary Care in BLMK (including NHSE Delivery Plan for Recovering Access to Primary Care)

The Board received a progress report on the development of integrated neighbourhood working in BLMK, based on the principles in the Fuller Report and provided assurance on the ICB's response to the NHS England recovery plan. Board members commented that further consideration needed to be given to communications with the public about how primary care was changing. Feedback from the Board suggested that a faster pace for some elements of the programme would be beneficial as well as clarification on how the outcomes will be measured and clarity on how partners can be involved in this important work.

Carnall Farrar Review of the Development of Health and Care Integration in Milton Keynes (MK)

Michael Bracey, Chief Executive, Milton Keynes City Council, introduced the report in which there was positive recognition for the partnership working in MK and some suggestions for improvement to the MK Deal, such as more extensive use of population health data, needing longer-term security around funding, the need to consider the long-term vision for MK health and care integration and to build resilience into the team.

The Board approved the next steps to develop a framework by June 2024 which sets out how greater responsibility for resources and decision making will be made available to place based partnerships as they mature.

The Provider Selection Regime (PSR)

The Board received an update on a new statutory responsibility that is expected to come into force on 1 January 2024. The PSR will be a set of new rules for procuring health care services in England by health organisations and local authorities. The introduction of the PSR requires the ICB and all partner organisations within scope to review procurement, contracting, commissioning and governance processes, both current and future, to ensure these are in line with the requirements of the Regime. The ICB and its partners also need to ensure that where joint commissioning or collaborative arrangements are in place, all partners are clear on responsibilities and accountabilities, and decision-making is transparent and consistent.

Financial and operational updates and system assurance

Members received formal updates from quality and performance and finance and investment committees as well as reviewing system risks and the Board Assurance Framework. They also discussed the reports from the place-based partnerships in all four boroughs.

The Board approved the request to extend the contract for the ICB Business intelligence support services with Arden GEM for a further one year (and possible additional year). The Board also noted the update on the work undertaken by the HR team on the Workforce Race Equality Standard and the Corporate Governance Update and reports from other Committees.

The ICB is strengthening its approach to system risk management involving all seven NHS providers in the system. Vineeta Manchanda, the Chair of the Audit and Risk Assurance Committee, has met with all the chairs of provider audit committees and they have been invited to future meetings of the ICB's Audit and Risk Assurance Committee.

Work is underway to review the current system risks and to develop a more granular system risk register which will bring a sharper focus on the related programmes of work required across the system. This will also involve reviewing the current risks on the Board Assurance Framework (BAF) and aligning risks on the system risk register to one or more risks on the BAF.

A summary of the BAF is shown below.

Ref	Risk Title	Risk Description	Current Risk Rating	Change
BAF0001	Recovery of Services	There is a risk that the NHS is unable to recover services and waiting times to pre-pandemic levels due to Covid related pressures, or demand led pressures. This may lead to poorer patient outcomes and reputational damage.	20	
BAF0002	Developing suitable workforce	If system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce then staff experience, resident outcomes and the delivery of services within the ICS, ICB People Responsibilities and the System People Plan are threatened.	20	
BAF0003	System Pressure & Resilience	As a result of continued pressure on services from various factors (staff sickness, increased activity etc) there is compromised resilience in the system which threatens delivery of services across BLMK	20	
BAF0004	Widening inequalities	There is a risk that inequalities in the system widen due to a range of factors leading to compromise to population health and increases in system pressure in the most deprived areas.	20	
BAF0005	System Transformation	There is a risk that as a result of significant operational pressures, there will be decreased capacity to focus on strategic transformational change to deliver improved outcomes for our population.	20	
BAF0006	Financial Sustainability and Underlying Financial Health	As a result of increased inflation, significant operational pressures, elective recovery and the enduring financial implications of the covid pandemic - there is a risk to the underlying financial sustainability of BLMK that could result in failure to deliver statutory financial duties.	20	
BAF0007	Climate Change	Due to climate change and wider impacts on the environment and biodiversity, there is a significant risk of increased pressure on health and care services.	16	
BAF0008	Population Growth	As a result of fast rate of population growth in BLMK, there is a risk that our infrastructure will not keep pace with the needs of our population, resulting in poor health and wellbeing for residents.	20	
BAF0009	Rising Cost of Living	As a result of rising cost of living there is a risk that residents will not be able meet their basic needs resulting in deteriorating physical and mental health resulting in pressure on all public services	16	
BAF0010	Partnership Working	There is a risk that the development of the ICS's public position on an issue is inconsistent with the public position of one or more partner member, resulting in a lack of clarity for the public and stakeholders	9	
BAF0011	Health Literacy – Denny Review	As a result of challenges with health literacy and understanding of health services as identified in the Denny Review, there is a risk that members of minority, disadvantaged and seldom-heard communities in BLMK are not able to properly access or navigate between health and care services, potentially leading to an exacerbation of health inequalities, increasing a sense of fragmentation between services, and resulting in adverse health outcomes.	16	NEW

4.2 Bedfordshire, Luton and Milton Keynes Integrated Care Board – Private Meeting

The private meeting of the Board of the ICB took place on 8 December 2023 and included the following items.

BLMK Local Maternity and Neonatal System (LMNS) Report

The Chief Nursing Officer at NHS England requested that all ICB Boards receive an update on the work of the LMNS. This report provided an overview of the current priorities and quality and safety challenges facing the system.

The report referenced the improvement work currently underway at Bedfordshire Hospitals NHS Foundation Trust (BHFT) and the recent CQC reports from visits carried out in August and September 2023.

A Maternity Safety Summit took place at Luton and Dunstable Hospital on 10 October 2023 including the Trust's senior leadership and the Regional Chief Midwife, as well as senior leaders from the ICB.

The Board will take a further report on this issue at its public meeting on 22 March 2024.

Provider Selection Regime
The Board received a verbal update from the Chief Transformation Officer about the new Provider Selection Regime (PSR) expected to come in effect from 1 January 2024. Contracts held by the ICB that are due to expire over the next 18 months have been reviewed in the context of the PSR.

Discussions will be held with providers in relation to community mental health and associated contracts due to expire in March 2025 to work through the benefits and risks of extending those contracts.

For contracts already out for procurement (such as musculoskeletal services) the current process will continue.

A number of very small value contracts (typically below £10,000) are proposed to be converted to grants.

4.3 BLMK Health and Care Partnership

The latest meeting of the Bedfordshire, Luton and Milton Keynes Health and Care Partnership (H&CP) took place on 31 October 2023. The main points covered at the meeting are as follows.

Health and Care Partnership Governance, Work Programme and Approach for 2023/24.
The Health and Care Partnership agreed to change its terms of reference to reflect a move towards fewer formal meetings enabling more time for joint working with members of the Board of the ICB.

Denny Review.
The H&CP discussed the findings of the review carried out by Reverend Lloyd Denny into health inequalities and partner members committed to the actions outlined in the report to tackle inequalities.

Delivering our Strategy at System and Place – Reports from the Health and Wellbeing Boards and ICB.
Updates from the ICB and each Place Board were received.

Health and Employment outline strategy framework.
Following the joint seminar between the ICB and the H&CP in July (as reported above), the H&CP supported an outline strategy framework for system-wide working on employment and skills.

Right Care, Right Person.
Across BLMK, partners are aiming to ensure that the right agencies are involved in provided appropriate levels of healthcare support and, in particular, working to reduce the need for police services to get involved in health-care issues.

NHS Operational Planning 2024/25.
Anne Brierley, the ICB's Chief Operating Officer outlined changes to operational planning in 2024/25 which seeks to take a system wide approach to addressing

financial and operational pressures and to shift resources towards supporting admission avoidance and discharge from acute settings.

4.3 Early Years Seminar

The Integrated Care Board (ICB) and Health and Care Partnership (HCP) held its second strategic seminar on Early Years on 24 November 2023 in Milton Keynes. Nearly 70 delegates attended the event including representatives from Parent Carer Fora, Council elected members and officers, early years schools and SEND professionals, public health, NHS organisations and the ICB.

Michael Bracey, Chief Executive of Milton Keynes City Council, and Matthew Winn, Chief Executive of Cambridgeshire Community services were the executive sponsors for the seminar and were keynote speakers at the event. Michael reflected that it had been 20 years since the publication of Every Child Matters which set out a clear and ambitious policy framework for putting children and families at the centre of our work, but he challenged on what has really changed in that time, except demand for services have increased Matthew stressed the importance developing a holistic view of the child in the context of their family, community and wider support network, emphasizing the need to move from a service-led to a needs-led approach. At present many children wait for specialist services when earlier assessment of needs and bespoke support from multi-disciplinary teams could meet needs quicker and more locally.

At the seminar, there were two interactive sessions based in the four places of Bedford Borough, Central Bedfordshire Luton and Milton Keynes. The groups were chaired and facilitated with the aim of agreeing a high-level action plan for each place to be agreed at Place Board level. The two questions the workshop groups focused on were:

- In identifying gaps in existing pathways and when considering the needs of our local children and families – what do we need to change?
- How do we achieve our ambition, agree the right strategic outcomes and what actions should we take in the short, medium and long term.

The summary of the Place based group discussions will be reported to Milton Keynes Health and Care Partnership, to consider what actions will be taken to address the local challenges.

5.0 Next Steps

None

List of appendices

None

Background reading

Public Board papers can be found on the ICB's website.

Meeting Title	**Trust Board of Directors**	**Date: January 2024**
Report Title	**Serious Incident Report**	**Agenda Item Number: 9**
Lead Director	**Dr Ian Reckless, Chief Medical Officer and Deputy Chief Executive** **Kate Jarman, Chief Corporate Services Officer**	
Report Author	**Tina Worth, Head of Patient Safety & Legal Services**	

Introduction	This report provides a monthly overview of management processes/systems in relation to serious incidents in the Trust.		
Key Messages to Note			
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 December 2023

There were six new Serious Incidents reported on STEIS in December 2023. See table below.

Reference	Division	Category	Details
2023/21778	Medicine	Infection	MSSA - hospital acquired
2023/21780	Medicine	Sub optimal care	Inappropriate human bite wound treatment
2023/21995	Women's Health	Maternity incident	Baby sent for therapeutic cooling after delivery – referred to the Health Care Safety Investigation Branch for independent review.
2023/21996	Women's Health	Maternal death	Woman who was 22 weeks pregnant died at home. referred to the Health Care Safety Investigation Branch for independent review.
2023/22401	Surgery	Medication error	Error in administration of medication
2023/22731	Medicine	Never event (no harm)	Bone marrow biopsy carried out on incorrect patient (patient answered to the wrong name).

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 below:

- Ongoing high volume of community pressure damage (patients admitted with pressure damage)

- Delays in diagnosis associated with delays in imaging reports/ reports being reviewed, especially relevant for outsourced reviews. Possible mitigation is for an 'external reporter' Co-ordinator who would monitor track external referrals. Risk assessment pending and addition to the risk register.

- Incidents relating to pressure in the ED & the impact this is having on staff and their ability to document care effectively and in a timely way on high-use computer devices. There is a discussion regarding laptops and IT infrastructure to mitigate risk.

- Continued number of incidents relating to violence and abuse (patients to staff) – process in place to provide support and continue to work to prevent incidents occurring

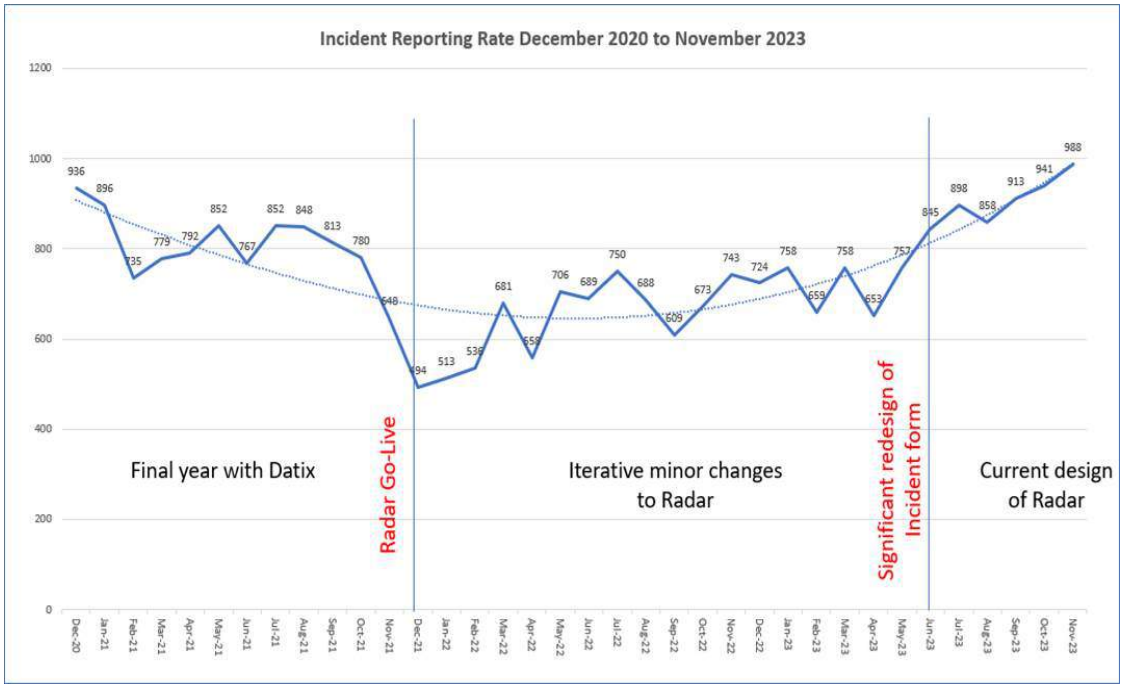
- Medication incidents relating to 'to take out' medications – ongoing QI work linked to discharge summaries

- Medication incidents (double administration of Paracetamol/Co-Codamol) – alert flag in place on eCARE.

Radar and incident reporting

The incident reporting rate (see graph below) has improved, with the following summary showing:

- The decreasing trend over the last year with Datix (however, reporting was unusual during Covid-19).
- A large dip when we first went live with Radar – bearing in mind we didn't just change system we also added in NHS England's form which added considerable burden on reporters needing to complete two forms.
- There was then a gradual increase in reporting as staff got used to Radar and we made small incremental changes to the form based on feedback from staff.
- A steep increase in reporting since June 2023, when we merged the NHS England form with our local form – so staff now only have one form to complete.



Going back as far as 2018, November 2023 was the highest reporting month on record so far. This demonstrates that from reporting perspective, Radar is working well.

Addressing Overdue Radar Incidents

Prior to Christmas following validation half days with the divisions the overdue number was considerably reduced however following the festive period this is now on the increase and up to 596 with 137 sitting with Women's Health.

Some incidents are now closed at PSIRF triage and there is ongoing work required with corporate nursing to agree a process for closure of falls and pressure ulcers which are aligned to level three quality improvement (QI) work.

The proposal is for the divisional triumvirates to hold weekly meetings with their Patient Safety Leads to review and close incidents which will significantly impact on the number of overdues and enable local learning, proposals for QI work and incident trends.

Moving to the Patient Safety Incident Response Framework (PSIRF)

A transition plan has been developed and will be shared at Patient Safety Board this month. A transition date of 1st April 2024 has been agreed. Highlights include:

1. Pilot

   A pilot of the Patient Safety Incident Response Framework (PSIRF) is currently covering all patient safety-related incidents in ward 23, ward 1, imaging and the emergency department. All community pressure ulcers are closed on Radar after the daily triage panel. 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

2. Training

   In house PSIRF training has commenced and will run through until late April 2024. It is being offered to approximately 200 staff members who are being nominated by their ward/department as key individuals who will be leading on patient safety incident response in their areas.

   Level 1 of the National Patient Safety Syllabus is awaiting approval to become mandatory for all MKUH staff.

3. Radar changes

   The necessary changes are currently being made to the Radar system to support transition to PSIRF. Testing of the new workflows and forms will commence later this month.

4. Communications

   A patient and family leaflet has been co-designed by the patient safety partners and a public comms plan is being developed with the comms team.
   A PSIRF information portal is available on the intranet for staff and a ‘drip feed’ approach is being taken with regards to comms via the homepage and CEO message.

5. Meetings/boards

   Relevant patient safety related meetings and boards are under review to ensure that report templates and TORs reflect the changes required for PSIRF. This includes a focus on learning, sharing of easily accessible, relevant information and providing clear pathways between patient safety and quality improvement.

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 December 2023, the following individual learning/reflection/discussion or ‘what’s trending’ points have been shared with the following themes:

- 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 and also maintain good hand

hygiene practices.

- Oxygen is one of the most commonly used drugs in the hospital in both emergency and non-emergency situations. It must be regarded as a drug and therefore prescribed correctly on the patient's drug chart. This includes details such oxygen delivery device, starting dose and administration

- How can we ensure that any results from scans or other tests are followed up and reviewed in a timely fashion? It remains the responsibility of the 'requester' and requesting department to check and action results. However, none of us work 24/7, so this responsibility can be shared with other members of the requesting team provided a thorough and safe handover has taken place.

- Recognising and managing deteriorating patients is one of the Trusts top safety priorities for 2024 under the new patient safety incident response framework, or PSIRF.

- To help us to make positive improvements in the care of deteriorating patients, we need to learn from what is working well and where we could do better.

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

Inquest previously adjourned and awaiting new date. 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 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

Inquest previously adjourned since HM Coroner unwell. Awaiting new date. In recent months there have been a number of post endoscopic procedural cases reported to HM Coroner. The Associate Medical Director has prepared a thematic review of these cases, including analysis of standardised activity and outcome data for index endoscopic procedures. This is being shared with HM Coroner in advance of the inquests.

Forthcoming Inquest 3:

Due to the patient's low blood pressure and electrolyte imbalance, she was to be cared for by the assistance of two. However, a nurse/HCA who had tried to lift her into bed from a chair/commode and hit her leg on the edge of the bed which led to a large haematoma. Passed away 6 months later. Cause of death 1.a. Frailty of Old Age 2. Lower Limb Haematoma. Daughter stated that following the haematoma patient didn't walk independently again.

All staff involved in the manual handling incident are required to attend.

Forthcoming inquest 4:

The patient was admitted with discitis, and she received six weeks of intravenous antibiotics and a repeat magnetic resonance imaging (MRI) showed improvement. She then began to feel unwell with symptoms of dysuria. A short course of Gentamicin was prescribed. On the 13th of May 2023, she was given a dose of Gentamicin which she should not have had as blood levels were too high. This administration may have exacerbated renal failure. She further deteriorated and was placed on end of life care.

Meeting Title	Trust Board	**Date: January 2024**
Report Title	Maternity Assurance Group	**Agenda Item Number: 9**
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 areas discussed and reviewed at MAG for October and November 2023 are summarised below: Standing items included the following: • The Maternity Governance Report • Perinatal Quality Surveillance Model updates • Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme Year 5 • Ockenden Assurance MAG received the following reports: • **Perinatal Quality Surveillance Model (PQSM)** The PQSM is a quality oversight tool that seeks to provide consistent and methodical oversight of maternity. The items summarised below were discussed as part of the PQSM report. 1. The Perinatal Mortality Review Tool (PMRT) was used to review one stillbirth, which graded the care as A (no issues with care identified) before and after the stillbirth was identified. 2. There were seven moderate harm incidents for the reporting; on further review, four were identified as no/low harm, one moderate harm, and two cases were awaiting review. 3. An update on the progress related to the NHS Resolutions Maternity Incentive Scheme (MIS) 10 Safety Actions. All 10-safety action have been met. The LMNS have reviewed the evidence submission for MKUH MIS 10 Safety Actions and have agreed there is sufficient evidence to meet all. An MIS paper to be presented at Trust Board in January 2024 to ensure: 1. The Trust Board agree and are satisfied that the evidence provided demonstrates achievement of all 10 safety actions. 2. The Trust Board agree the Board declaration form can be electronically signed by the Trust CEO. 3. The Accountable Officer of the ICB signs the board declaration form. 4. Notification sent to NHS Resolutions before 12 noon 02 01/02/2024

4. Training Updates

- **Maternity emergencies: 98%**(MW 99%, MSW/MCA 93%, Obs 100%, Anaesthetists 94%).
- **Fetal monitoring: 89%** (MW 98%, Obs 100%).
- **Neonatal life support**: 94% (MW 93%, Paeds 96%, ANNP 100% NNN 100%).
- **GAP GROW/SBL**: 96% (MW 96%, Obs 93%)

- **Maternity Staffing**

1:1 care in labour was 100% as was Labour ward coordinator supernumerary status. The fill rate was 95.1% and the Midwife to Birth ration was 1:33

- **Culture Survey Update**

Discussions around civility being a cornerstone to practice and keen for cultural conversations to continue within the department. Plan is to review the culture survey alongside the NHS staff survey to support further improvement work. Further workplace champions to be established within the division and Involve Freedom to Speak Up within the culture work.

- **Increase in Births**

There continues to be proactive arrangements put in place to support to support an anticipated increase in births between December and January, which included additional elective caesarean section lists being confirmed.

- **Formula Milk**

Information is to be provided to service users in relation to formula milk not being available within the Trust In line with the National Baby Friendly Initiative (BFI).

- **Antenatal Day Assessment Unit**

There has been an increase in feedback from service users feedback in relation to waiting times in ADAU, particularly for those waiting for obstetric review. A review of the ADAU pathway is currently underway to understand and reduce the waiting times.

- **Review of ITU Admission**

In 2023, six service users requiting ITU admission from Maternity. A review of the cases has not found anything significant. To ensure there have not been any missed opportunities for learning, an external review of these cases has been commissioned by the Trust. It is expected to be completed by the end of February 2024.

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 November and December 2023
Next Steps	N/A
Appendices/Attachments	N/A

Maternity Assurance Group (MAG)

Meeting Date:	26th October 2023	**Meeting Time:**	08:00 – 09:00
Location:	Microsoft Teams		

Present:	**Name**	**Job title**	**Initials**
	Alison Davis (Chair)	Chairman and Non-Executive Director	AD
	Yvonne Christley	Chief Nursing Officer and Maternity Safety Champion	YC

In attendance:	Jenny Barker, Interim Operations Manager, Women & Children Katie Selby, Maternity Governance and Quality Lead (KS) Dr Lazarus Anguvaa Mary Plummer, Maternity Matron (MP) Natalie Lucas Dr Vicky Alner, Divisional Director, W&C (VA)
Apologies:	Dr Ian Reckless, Chief Medical Officer and Maternity Safety Champion (IR) Katy Philpott, Associate Director of Operations, W&C (KP) Miss Nandini Gupta, Clinical Director Obstetrics and Gynaecology (NG)
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 26th October 2023 were accepted as an accurate record.	
4.	**Action log and matters arising**	
	Action 2: CNST - Midwifery workforce BirthratePlus paper taken to EDs. Funding for the 6 extra midwives agreed in budget. Action closed. **Action 18: BSOTS** Manual data collation for a period of 1 month. Update MAG in November. **Action 24: Maternity bookings**	

	VA to discuss raw figures with Obstetrics and Maternity, with a view to providing MAG with assurance around workforce, internal contingency/escalation policies, NNU etc. Meeting Scheduled Tuesday 31st @ 11:00. **Action 25: Culture Survey** Agenda item in November, fuller discussion including Erum Khan.	
	Standing items	
5.	**Perinatal Quality Surveillance Model**	
	Report taken as read. The following additional comments were highlighted and discussed: • MDT Training: Following the recent doctors strikes, NHSR have reduced the percentage to 80% until December, when it will return to 90%. Additionally, Obstetric colleagues who have had recent training in another Trust can now bring it with them. KS has inquired if this can be extended to anaesthetic colleagues. KS assured MAG that she is confident the 80% target will be met, potentially 90%. • Smoking cessation: MAG was assured that as part of the Opt out house smoking cessations referrals family members in the household who smoke will be offered a referral. • Supernumerary Status labour ward coordinator 96% SN with 1:1 care provided once: Half hour window before handover, escalation process not followed. Staff member advised that if escalated support would have been forthcoming.	
6.	**CNST**	
	Report taken as read.	
7.	**Ockenden**	
	Report taken as read.	
8.	**Governance report**	
	Report taken as read.	
	Assurance	
9.	**PMRT report**	
	KS provided a verbal overview as per the PDF circulated prior to the meeting, the following additional comments were highlighted and discussed: • Still birth: KS advised that MKHU will analyse still birth data singularly ahead of overarching LMNS investigation. Bedfordshire hospitals have also seen an increase in their still birth rates.	
10.	**Maternity Experience report**	
	• NL advised that a new theme has been identified around the experience of early pregnancy care when attending A&E. Collaborative work is ongoing to improve pathways, patient experience, and patient expectations.	
11.	**ATAIN & TC report**	
	KS provided a verbal overview as per the PDF circulated prior to the meeting, the following additional comments were highlighted and discussed:	

	• Workstream ongoing around infection admissions to identify themes for teaching, specific to maternity.
	• ATAIN admissions for September = 8.5%. Possible reasons for increase:
	  ○ National admission percentage is 6%, however this does not consider demographics and MK has seen an increase in service users who are at higher risk of being admitted.
	  ○ Admission is now recorded from the minute baby arrives in NNU, previously after 4 hours.
	  ○ National reporting relates to avoidable and unavoidable. 70% of babies in Q2 were unavoidable. 58% of these could have been TC, thus avoiding maternal/infant separation. VA advised that the revenue business case for a 6 bedded TC on Ward 10 is currently sitting with Charlie Nunn for a review of nursing costs. It was noted that the elevated forecast of deliveries is likely to see a higher proportion of babies going to NNU unless we have a proper TC unit.	

12.	**CQC survey**	

	NL provided a verbal overview as per the PDF circulated prior to the meeting, the following additional comments were highlighted and discussed:
	
	• Women who are breastfeeding are reporting a lack of support. To mitigate this, the Infant feeding lead has implemented the following:
	  ○ Walkarounds in all areas to identify issues early.
	  ○ Receiving referrals from women who have experienced difficulties previously to put additional antenatal support in place.
	Thought is being given to how to support women better during the evening.	

13.	**Neonatal Medical Workforce action plan (MIS SA4)**	
	• 14th Consultant interviews are scheduled for the 14th of November. It is hoped that this will facilitate additional time for consultants to work on NNU. On paper, 14 people is enough to give everyone a minimum of 4 weeks on NNU, however, this does not work in a substantive job plan. It is estimated that an establishment of 18 Consultants is required to facilitate this, the plan is to transition over the next few years. • Recurrent funding has been awarded from NHS England for an equivalent of 2.5 PA Neonatal Consultant time. This will used to secure PA for colleagues to carry out Neonatal admin.	
13.	**AOB**	
	• KS reported that there has been a recent High Court judgement around HSIB (now MNSI) cases having to release transcripts from interviews. This has caused some unease amongst those involved in maternity investigations. KS expressed concern around transparency of future investigations if people feel they are unable to be candid. No additional guidance is expected from MNSI, although they have confirmed that staff are now permitted to invite a union rep or any other representation.	
14.	**Date and time of Next Meeting**	
	Thursday 23rd November 2023 @ 08:00-09:00 via MS Teams	

Maternity Assurance Group (MAG)

Meeting Date:	23rd November 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 Officer and Maternity Safety Champion	IR
	Yvonne Christley	Chief Nursing Officer and Maternity Safety Champion	YC

In attendance:	Elaine Gilbert, Divisional Chief Midwife (EG) Katie Selby, Maternity & Gynae Clinical Governance and Quality Lead (KS) Miss Erum Khan, Labour Ward Lead and Maternity Safety Champion (EK) Dr Lazarus Anguvaa, Consultant Paediatrician (LA) Lisa Viola, Neonatal Safety Champion (LV) Mary Plummer, Maternity Matron (MP) Miss Nandini Gupta, Clinical Director Obstetrics and Gynaecology (NG) Dr Vicky Alner, Clinical Director, W&C (VA) Dr Zuzanna Gawlowski, Consultant Paediatrician (ZG)
Apologies:	Jenny Barker, Interim Operations Manager, Women & Children (JB) Katy Philpott, Associate Director of Operations, W&C (KP)
Minute Taker:	Nicky Peddle – EA to Chief Medical Officer

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 26th October 2023 were accepted as an accurate record.	
4.	**Action log and matters arising**	
	Action 18: BSOTS Manual data collation for a period of 1 month. Feedback awaited, carried forward to January 2024.	

	Action 23: Community connectivity Positive feedback received from community teams and IT. **Action closed**. **Action 24: Maternity bookings** VA reported on the anticipated higher demand for elective sections and general Labour Ward activity throughout December and January. Additional elective section lists have been confirmed in the afternoons during the week between Christmas and New Year, January tbc. **Action closed.** **Action 25: Culture Survey** Agenda item. For information, IR reported that the Letby/Thirlwall Inquiry was formally launched on 22nd November 2023. An in-depth questionnaire has been sent to Trusts, with the directive that the Medical Director and another executive with operational influence over the service complete without conferring. Out of the 44 questions, approximately 18 require specific data. After submission, the completed questionnaires will be brought to MAG for oversight. Score Survey administered by AHSM and completed in 2019 contained learning which may still apply. KS advised that the survey was repeated this year, however, there were not enough participants to collate evidence.	
	Standing items	
5.	**Perinatal Quality Surveillance Model**	
	Report taken as read. The following additional comments were highlighted and discussed: • Still birth data to be presented to MAG in January 2024. • Birthrate Plus – For note, Daphne Thomas, Interim Chief of Finance, has confirmed that the 6 WTE midwives were agreed at budget setting but put into reserves due to the number of vacancies in the department, they are part of the recruitable establishment and will be transferred into W&C when recruited.	KS
6.	**CNST**	
	Report taken as read.	
7.	**Ockenden**	
	Report taken as read.	
8.	**Governance report**	
	Report taken as read.	
	Assurance	
9.	**Workforce action plans (MIS Safety actions 4 & 5)**	
	Appendix 3 Neonatal Nursing and Medical \ <u>Obstetric workforce</u> NG spoke to the paper circulated, the following additional comments were highlighted and discussed: • Trusts/organisations should implement RCOG/BMI guidance on 11 hours compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident oncall out of hours and do not have sufficient rest	

	to undertake their normal working duties the following day. This is not achievable with current job plans. All but 1 Consultant has voted to opt out of this guidance. It was agreed that if a consultant has been up in the night and is unable to attend a clinical session in the morning, the session will be covered by other colleagues. SOP developed and currently following the governance process for agreement. It was recognised that that this is a pragmatic way forward in Obstetrics but there may be wider issues in other services. <u>Neonatal medical workforce</u> LA spoke to the paper circulated, there were no further comments. <u>Neonatal nursing workforce</u> LV spoke to the paper circulated, the following additional comments were highlighted and discussed: • MAG requested a robust action plan be developed around QIS following the planned establishment review. YC suggested that as natural attrition and turnover takes place, the unit should only recruit into QIS. Further discussion to take place outside this meeting. **Action** QIS action plan to MAG for review in February. <u>Midwifery workforce</u> KS spoke to the paper circulated, there were no further comments.	LV
10.	**Culture survey update**	
	EK spoke to the paper circulated, the following additional comments were highlighted and discussed: • MAG recognised that civility is one of the cornerstones of medical practice and confirmed they are keen to see cultural conversations start within the department, with the support of Kate Jarman and COMMS. • Incorporate general NHS staff survey and 2019 SCORE survey in baseline, allowing for improvement through all different metrics. • IR/AD/YC will take forward to Board level, in terms of how this should be approached across the organisation. • Workplace Behaviour Champions in place in Anaesthetics and Theatres, not yet established in Paediatrics. • Freedom to Speak up Guardian involvement suggested.	
11.	**Increase in birth**	
	Discussed under actions, nothing further to add.	
12.	**Formula milk review**	
	KS spoke to the paper circulated, the following additional comments were highlighted and discussed: • Implementation date 1st January, however, this will be a phased slow launch alongside planned communication. Little pushback is expected from most users as there is an expectation that if they are exclusively using formula feeding, they will feed their infants at their own cost. • Scheme is not driven by a desire to cut costs. MK is an outlier to still be providing milk. Most trusts only provide milk in extreme circumstances. • MP is working very closely with the infant feeding midwife, who continues with daily rounds to check on mothers who are having problems. Questions around breast feeding have been included in weekly Tendable audits to obtain early feedback and put in mitigations if there is no progress.	

13.	**AOB**	
	• IR reported that there has been a run of admissions of pregnant ladies into ITU. 5 cases where women peripartum have been admitted to ITU and 1 case of a woman in late second trimester with encephalitis. There do not appear to have been any obvious lapses. For assurance, MAG was supportive of commissioning a formative review of these cases, leading to a specific multi professional MDT.	
14.	**Date and time of Next Meeting**	
	Thursday 25th January 2024 @ 08:00-09:00 via MS Teams	

Meeting Title	**Trust Board**	**Date: January 2024**
Report Title	Nursing and Midwifery Biannual Safe Staffing and Inpatient Establishment Review	**Agenda Item Number: 11**
Lead Director	Yvonne Christley - Chief Nursing Officer	
Report Author	Deep Austin, Associate Chief nurse and Emma Thorne, Safe Staffing Matron	

Introduction	This report provides an overview of Nursing, Midwifery, and Allied Health Professionals (AHP) staffing at Milton Keynes University Hospital (MKUH) from June to November 2023. The report covers details of vacancies, fill rates, Care Hours Per Patient Day, Midwife Birth Ratio, inpatient establishment reviews, and a summary of improvement actions and activities. It also provides assurance of Trust compliance with the National Institute for Health and Care Excellence (NICE) Safe Staffing Guidance, National Quality Board (NQB) Standards, and the NHS Improvement (NHSI) Developing Workforce Safeguards.		
Key Messages to Note	• The steady reduction in RN/RM vacancies over the past six months, from 7.1% in June to 2.5% in November. The report outlines ongoing efforts to reduce vacancies, including international recruitment, Student Nurse to Staff Nurse Initiatives, and the Nursing Associate training programmes. • Healthcare support worker vacancies remain a challenge with a vacancy rate of 24% in November 2023. The Trust has collaborated with BLMK on a regional healthcare support worker recruitment campaign. As a result, the number of HealthCare Assistant vacancies is expected to decrease by 40% in January 2024. • The report demonstrates an improvement in the overall fill rate for nursing and midwifery during the day and an increase in the fill rate for HCAs during the day. • This nurse establishment review provides an updated position statement about the nursing workforce requirements needed to achieve safe staffing levels in the general inpatient areas, emergency department, and children's and young people's services within the Trust. • The review proposes changes to the nursing establishment on Ward 19, Ward 18, and Ward 22 in the Medical Division, Ward 20 in the Surgical Division, and Ward 5 in the Women and Children Division. • The Emergency Department will also seek investment to enhance the skill mix, headroom, and leadership structure. The Trust will initiate data collection for the second nursing establishment review in January 2024.		
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	
Next Steps	N/A
Appendices/Attachments	N/A

Nursing and Midwifery Biannual Safe Staffing and Inpatient Establishment Review

Introduction

This report provides an overview of Nursing, Midwifery, and Allied Health Professionals (AHP) staffing at Milton Keynes University Hospital (MKUH). This report provides details of vacancies, fill rates, Care Hours Per Patient Day, Midwife Birth Ratio, inpatient establishment reviews and a summary of improvement actions and activities.

Nursing and Midwifery Vacancies

RN/RM vacancies have continued to decline over the past six months. The vacancy rate for RN/RM has reduced from 7.1% (82wte) in June 2023 to 2.5% (29wte) in November. Healthcare Support Worker (HCSW) vacancies have increased from 22.9% (98wte) to 24.5% (108wte) in November.

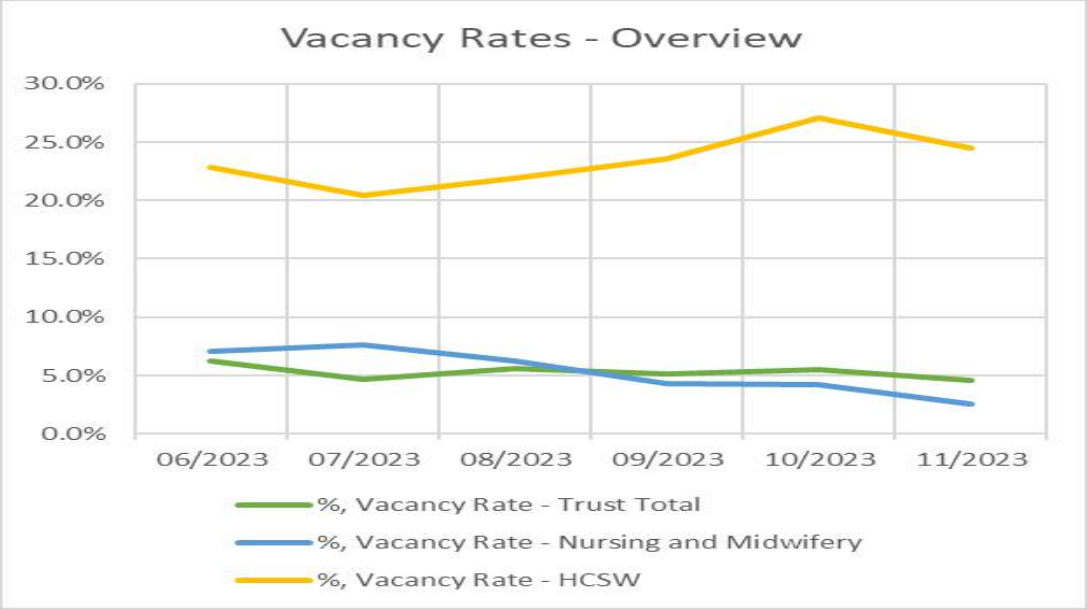


Table 1 below summarises nursing, midwifery and HCSW vacancies by staff group.

Table 1: Nursing, Midwifery and HCSW Vacancies (June - November 2023)

% Vacancy Rate - Nursing and Midwifery (Jun-Nov 2023)					
Jun 2023	Jul	Aug	Sept	Oct	Nov
7.1% (82 wte)	7.6% (88 wte)	6.2% (72 wte)	4.3% (50 wte)	4.2% (49 wte)	2.5% (29 wte)

% Vacancy Rate - Nursing Jun-Nov 2023					
Jun 2023	Jul	Aug	Sept	Oct	Nov
6.1% (61 wte)	6.4% (65 wte)	5% (51 wte)	2.7% (27 wte)	3.2% (32 wte)	1.7% (17 wte)

% Vacancy Rate - Midwifery (Jun-Nov 2023)					
Jun 2023	Jul	Aug	Sept	Oct	Nov

14% (22 wte)	15% (23 wte)	14% (22 wte)	15% (23 wte)	11% (17 wte)	8% (12.3 wte)

% Vacancy Rate – Healthcare Support Worker (Jun-Nov 2023)					
Jun 2023	Jul	Aug	Sept	Oct	Nov
23% (98 wte)	20% (88 wte)	22%(94 wte)	24% (100 wte)	27% (120 wte)	24% (108 wte)

The figures above do not include pre-employment candidates, of which 22 Healthcare Support Workers,47 Registered Nurses, and 16 Midwives are in the pipeline. Ongoing efforts have been maintained within nursing and midwifery to reduce vacancies. International recruitment programmes, Student Nurse to Staff Nurse Initiatives, and the Nursing Associate training programme have all decreased vacancies.

Although there has been a decrease in Registered Nurse vacancies, the inpatient paediatrics areas remain a concern with a vacancy rate of 19% (13 WTE). The Division has taken proactive steps to recruit, and currently, there are several Registered Nurses in pre-employment and undergoing OSCE preparation. As a result, the paediatric vacancy rate is expected to decrease to 0% by January 2024. In the meantime, the Registered Nurse vacancy rate is being addressed by long-line agency. Maternity has also reduced the vacancies to 12.3wte across the inpatient and community services, and recruitment continues to reduce vacancies.

The Trust has collaborated with BLMK on a regional healthcare support worker recruitment campaign. As a result, the number of HealthCare Assistant vacancies is expected to decrease by 40% in January 2024. Currently, there are 22 Healthcare Assistants in pre-employment.

Planned Versus Actual Staffing and Care Hours per Patient Day (CHPPD)

Planned versus actual staffing fill rate is calculated by the percentage of actual staff on duty (including the temporary workforce) against the established staffing. Over the last six months, there has been an improvement in the overall fill rate for nursing during the day, from 89% in June to 91% in November.

Figure 3 – Planned versus Actual Fill Rates for Registered Nurses

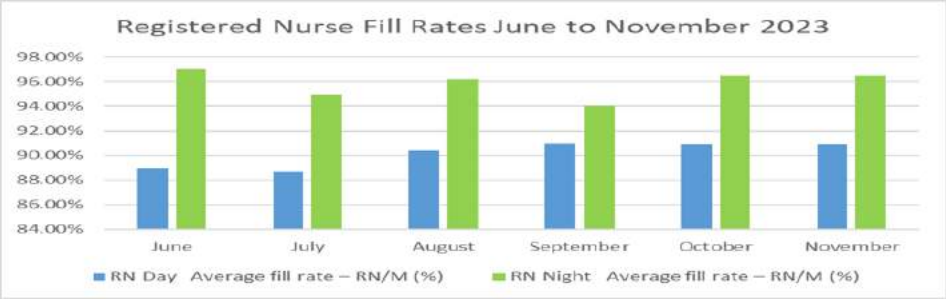


Figure 4 – Planned versus Actual Fill rates for Healthcare Assistants

There has also been an increase in the fill rate for HCAs during the day, from 82% in June to 96% in November 2023. The overall fill rate for registered nurses and HCAs remained above 90% for all areas.

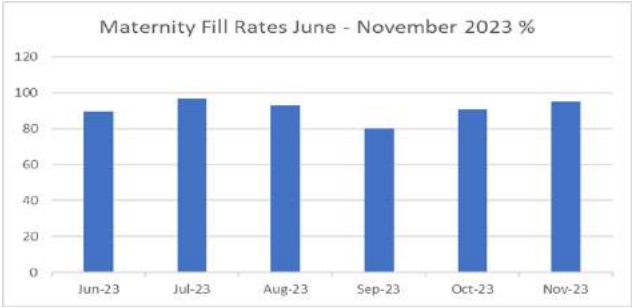
Significant work has been undertaken to improve fill rates in the last six months. This includes weekly review and analysis of fill rate reports, reviewing all wards' rota templates, and educating ward leaders on the importance of checking their fill rates for accuracy. Escalation areas also impact the overall fill rate as staff regularly move from wards to support escalation areas. The additional staffing requirements for the current escalation wards are 14 Registered Nurses and 11 HCAs during the day and 12 Registered Nurses and 9 HCAs at Night.

Maternity Fill Rates

In Maternity, the fill rate is calculated based on exact shift requirements month on month across the service – which are changeable depending on the community midwifery requirements. The midwifery staffing across all in-patient and outpatient areas dynamically adapts to meet the service needs, supported by the maternity escalation plan and midwifery business contingency plan. It is, therefore, necessary to review the midwifery staffing fill rate across the service instead of by area.

The graph below demonstrates Maternity fill rates remained around 90% throughout the reporting period except for September where there was a decrease in fill rates to 80.3%. This is due to an increase in maternity leave, study leave requirements and sickness absence. A revised approach to proactive maternity and study leave management has commenced to ensure fill rates stay within 90%.

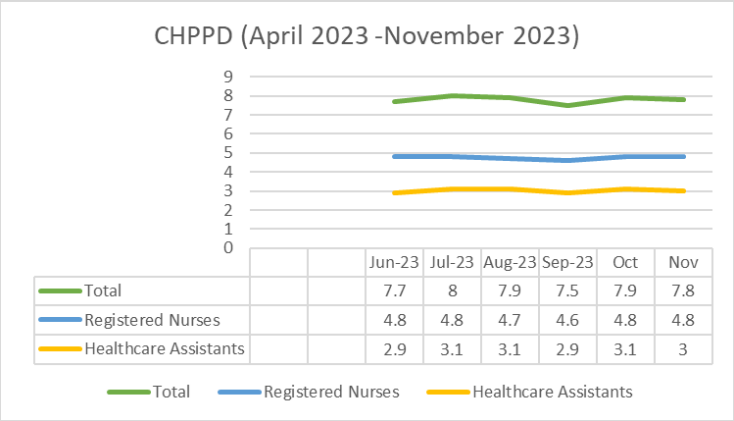
Figure 5 - Maternity Fill Rates



Care Hours Per Patient Day (CHPPD)

Care Hours Per Patient Day (CHPPD) is a key metric for recording nursing, midwifery, and HCA staff deployment on inpatient wards. CHPPD is calculated by adding together the hours of registered and unregistered staff and dividing the total number of patients in beds at midnight. This calculation provides a value of actual nursing care hours spent with patients a day. Low levels of CHPPD could indicate inadequate staff in proportion to patient numbers and high rates could indicate inefficient rota practice or incorrect shift plans. While there is no nationally set figure for CHPPD the national average is recognised as approximately 8.0. The Trust's CHPPD has consistently ranged between 7.5 and 8 in the last 6 months.

Figure 6 Care Hours Per Patient Day

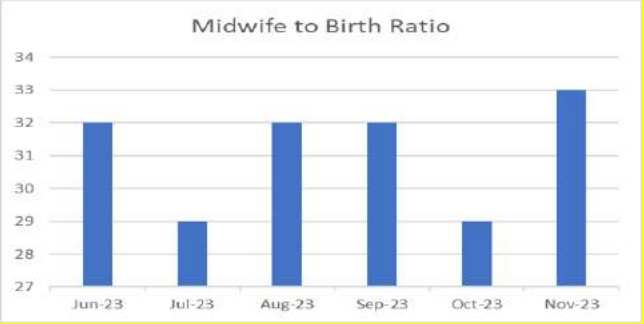


	Jun-23	Jul-23	Aug-23	Sep-23	Oct	Nov
Total	7.7	8	7.9	7.5	7.9	7.8
Registered Nurses	4.8	4.8	4.7	4.6	4.8	4.8
Healthcare Assistants	2.9	3.1	3.1	2.9	3.1	3

Midwife-to-Birth Ratio

The expected midwife-to-birth ratio at Milton Keynes is currently 1:28, which is based on the calculations following the Birth Rate Plus workforce report in 2018. The graph below demonstrates during the reporting period, midwife to midwife-to-birth ratio fluctuated between 1:33 to 1:29. The fluctuation has been impacted by staff unavailability and birth rate. There are ongoing plans in place to increase the establishments to meet the requirement. The Trust has agreed an uplift of 6 WTE Band 6 Midwifes in line with the Birth Rate Plus recommendations.

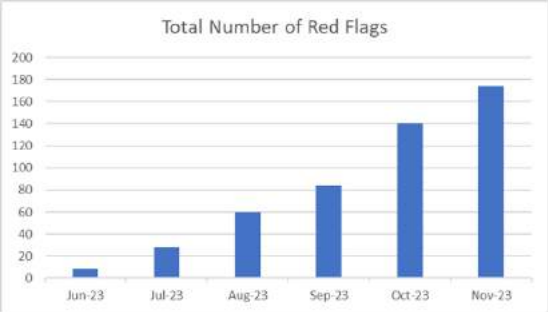
Figure 7 Midwife to Birth Ratio



Safe Staffing Red Flags

Red Flags are NICE-recommended reportable events warranting immediate staffing and patient acuity review. Any Red Flag raised will initiate a senior nursing review, and necessary mitigations are actioned to minimise the risk. Red Flag reporting was introduced in April and as the process has embedded has seen an increase in the number of Red Flags reported.

Figure 8 Red Flags

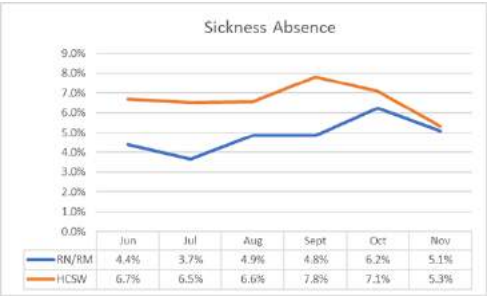


The increase in the reporting of Red Flags is a positive step forward and a demonstration of the embedding of a clear, safe staffing escalation and review process. The top reporting themes for Red Flags are a shortfall in registered nurse time and less than two registered nurses on a shift. Of the 174 red flags raised in November, 54 were resolved, and 117 remained open and 3 were raised in error. The focus in the coming weeks will be on recording the narrative and mitigation of open Red Flags.

Sickness Absence

The rates of sickness absence have been variable over the past six months and have ranged between 4.4% and 6.2% for registered nurses/midwives. HCSW sickness absence has also fluctuated ranging from 5.3% to 7.8%. Efforts to reduce sickness absence involve flexible working arrangements, training and development opportunities, supportive management, and regular engagement and communication that seeks feedback from staff and target interventions with the Divisional Chief Nurses/Midwife to reduce sickness absence below 4%.

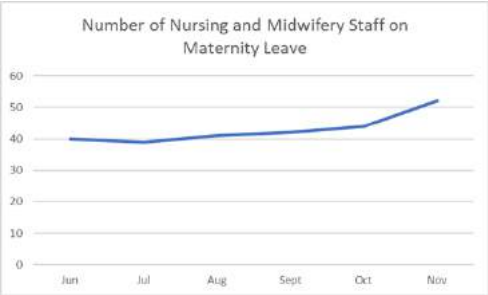
Figure 9 Sickness Absence



Maternity Leave

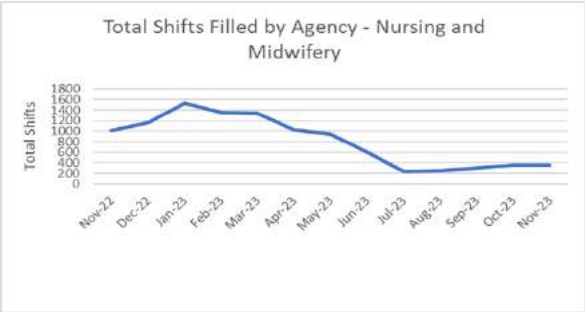
The graph below demonstrates the number of Nursing and Midwifery staff on maternity leave has ranged from 39 to 52 over the past six months.

Figure 10 Maternity Leave



Nursing and Midwifery Agency Usage

Agency use for registered staff has decreased over the past six months. The total number of shifts filled by Agency Nurses reduced from 1009 in November 2023 to 353 in November. The reduction reflects the implementation of the Trust's new agency booking process, which carefully reviews the requirements for the agency. Agency HCSW decreased from 274 in November 2022 to 0 in November 2023.The Trust uses agency staff to support increased capacity in specialised areas such as ICU, Paediatrics, Theatres, and Maternity, where bank availability is limited. The graphs below illustrate that significant and continued reduction in agency usage.



Allied Health Professional Staffing

The Therapy Department is an area of focus regarding vacancies. There are 6 WTE vacancies in the Occupational Therapy (OT) department, against a budgeted establishment of 18.15 WTE. The physiotherapy department vacancies have been reduced to 4.17 WTE against a budgeted establishment of 28.14 WTE. Similarly, the vacancies for the therapy support workers have been reduced to 3.36 WTE, against an establishment of 21.99 WTE.

The Therapy department has remained proactive with its recruitment processes. Hard-to-recruit posts such as oncology, orthopaedic, frailty, and rotational Band 6 posts have been recruited and are expected to start by January 2024. In the meantime, the oncology posts have been skill-mixed to increase the hours available and offer a split post across orthopaedics and frailty to support the frailty agenda in Wards. Several strategies have been implemented to enhance the AHP workforce. These are:

- Expansion of student placement and work experience to promote careers at MKUH.
- Engagement in AHP ICS workstreams with a focus on the OT profession.
- Growing our own through apprenticeships level 5 and 7.

As part of an initiative to reduce hospital-associated deconditioning, 8 Health Care Assistants (HCAs) and 1 Assistant Practitioner have been appointed to keep patients active while they are in hospital. The initiative, called 'Keeping You Active', began in mid-November. In support of the initiative, System Partners are developing a Care Academy training programme to train HCAs and reablement staff to help keep patients active.

Inpatient Establishment Reviews

The National Quality Board (2013) and Developing Workforce Safeguards require the Trust to conduct establishment reviews twice a year using an evidence-based tool. These reviews aim to ensure that existing establishments meet patient needs. In June 2023, the Trust commenced the first biannual nursing establishment reviews and data collection. Data was collected using the Adult Inpatient, Adult Assessment Unit Safer Nursing Care Tool (SNCT) and Emergency Department SNCT. Data was gathered once daily for 20 days in adult areas and twice daily for 12 days in the Emergency Department as per the SNCT guidance. Review meetings were held with all clinical areas, including the Matron and Ward Manager, to assess if the current establishments align with SNCT recommendations and professional judgment. A summary of all inpatient ward establishments can be found in Appendix 1.

1. **Adult and Pediatric Inpatient Wards**

   Overall, the adult inpatient ward establishment review indicates that wards have the correct establishment. The current funded establishment allows nurse-to-patient ratios to remain below the ratio of 1:8 (day) and 1:10 (night). The review has also identified three inpatient areas with triangulated evidence with professional judgement, red flags, staff satisfaction, patient acuity, and dependency to indicate a revised skill mix to meet patients' needs.

   1.1 Medical Division

   The Medical Division requires revisions to Ward 19, Ward 18, and Ward 22 establishments. The proposed changes to these establishments are summarised in the tables below. The acuity and dependency on Ward 19 have

increased, and the proposed improved registered nurse skill mix reflects the complex needs of patients. Similarly, an increase in Registered nurse staffing at night is proposed for Ward 18 and is supported by SNCT acuity and dependency data.

Ward 19	Registered Nurse	Healthcare Support Worker
Current skill mix (Day)	4	5
Recommended skill mix	5	4
Change	+ 1 Registered Nurse	-1 Healthcare Support Worker
Current skill mix (Night)	3	3
Recommended skill mix	4	3
Change	+ 1 Registered Nurse	0

Ward 18	Registered Nurse	Healthcare Support Worker
Current skill mix (Night)	3	3
Recommended skill mix	4	3
Change	+ 1 Registered Nurse	0

Ward 22	Registered Nurse	Healthcare Support Worker
Current skill mix (Day)	4	4
Recommended skill mix	4	3
Change		-1 Healthcare Support Worker

Acute Assessment Areas (Ward 1 and Ward 2A)

Acute Assessment areas are recommended to operate to the nurse-to-patient ratio of between 1:6 -1:7. Ward 1 runs on a nurse-patient ratio of 5.2 during the day and night, and no adjustments to the skill mix or ratio are recommended. In relation to Wards 2A, the review supports an increase in the Registered nurse-to-patient ratio at night. Therefore, the change below should be made to the funded nursing establishment at night.

Ward 2A	Registered Nurse	Healthcare support Worker
Current skill mix (night only)	4	3

Recommended skill mix (night only)	5	3
Change	+ 1 Registered Nurse	0

1.2 Surgical Division

The Surgical Division requires one amendment to the establishment on Ward 20 to ensure appropriate registered nurse support at night to meet patients' acuity and dependency needs.

Ward 20	Registered Nurse	Healthcare Support Worker
Current skill mix (Night)	3	3
Recommended skill mix	4	2
Change	+ 1 Registered Nurse	-1 Healthcare Support Worker

1.3 Women and Childrens Division

The Women and Children Division requires an amendment to the staffing establishment in the Ward 5 Pediatric Ward at night. The Royal College of Nursing Defining Staffing Levels for Children and Young People Services outlines the recommended safe staffing ratios for children of all ages. The RCN guidance on nurse-to-patient ratios is as follows:

Under 2 years	1:3
Over 2 years (Day)	1:4
Over 2 years (Night)	1:5

The proposal is to increase the number of Registered Nurses in Ward 5 at night by two nurses because of the increase in children under 2 in the past six months. The SNCT data support these changes and will be repeated in January 2024.

Ward 5	Registered Nurse	Healthcare support Worker
Current skill mix (night only)	4	1
Recommended skill mix (night only)	6	1
Change	+ 2 Registered Nurse	0

1.4 Emergency Department

The Emergency Department (ED) Safer Nursing Care Tool (2021) was used to calculate nurse staffing requirements for ED based on patient needs (acuity and

dependency). The Emergency Department (ED) establishment review was underpinned by:

- The ED Safer Nursing Care Tool evidence
- Professional judgement
- Benchmarking against other type 1 Emergency Departments
- Application of the recommendations from the RCN/RCEM (2020)
- Patient and workforce metrics and outcomes

The Emergency Department will seek additional investment and amendments to the current nurse staffing establishment to ensure the skill mix, headroom and leadership structure. The division is in the final stages of developing a workforce plan and business case to enhance and strengthen the skill mix rather than increase the number of registered nurses and HCSW within the department.

Next Steps

The Trust is planning to initiate data collection for the second nursing establishment review in January 2024. Data is collected twice a year to compare seasonal variance and benchmark staffing establishments against peers of similar size. The Trust will work towards the recommended 65% registered nurse to 35% HCSW ratios in this next review. The decisions regarding ratios are made on a ward-by-ward basis, with professional judgment and evidence-based practice being applied.

Safe Staffing Improvement Actions and Activities

- **Safe Staffing Meetings and SafeCare**

Formal Safe Staffing Meetings have been introduced three times daily. During these meetings, the live SafeCare system is utilised to ensure that Red Flags raised are reviewed, mitigated, or escalated and that wards/departments at risk receive the support required to provide safe and effective care. The Safe Staffing Matron chairs the meeting, and attendance is required from all Divisions. Wards must input patient acuity and staffing data into the live system three times daily to provide an overarching picture of the ward's safety. Data entry compliance now sits at 90% Trust-wide.

- **Safe Staffing Escalation Policy and Procedure**

A Safe Staffing and Escalation Policy was developed and approved by the Trust Executive Committee in December. The policy outlines the escalation process when

staffing falls below plan, how staff can escalate and raise concerns and how to mitigate risk, ensuring safe care.

- **Check and Confirm Roster Efficiency**

Monthly Check and Confirm meetings continue to optimise workforce efficiency and ensure that staffing is spread evenly across the breadth of the rota. This process ensures wards create and publish safe and effective rosters per national guidelines and working time directives. By doing so, the Trust can ensure that appropriate staff are available at the necessary times to provide patient care.

- **Nursing and Midwifery Recruitment and Retention**

Over the last six months, the rate of vacant positions for Registered Nurses/Midwives (RNs/RM) across the Trust has consistently decreased. One hundred eighty internationally educated nurses have passed their OSCE exams and are officially registered with the NMC. The Divisional Chief Nurses are working with the remaining nurses to fill the available vacancies. In addition, the nurses' career aspirations are being considered to ensure that they are placed in positions that are a good fit for them. To support our internationally educated nurses, the Trust has recruited a career coach to help with their development and retention at MKUH. Core Skills development days have also been developed and implemented in addition to those offered in the preceptorship programme. Clinical programmes are also being designed for Matrons, Band 7 and Band 6s. The matron development programme is scheduled to start in January 2024.

- **HCSW Recruitment and Retention**

The Trust has established an HCSW Recruitment and Retention Steering Group. The group has worked with BLMK to develop and implement a campaign that has recruited 47 HCSWs. The group are also working on improving the HCSW recruitment process from advertisement to induction to ensure everything runs smoothly. Introductory welcome letters and information booklets about the wards and departments are being developed to ensure those new to care have an improved understanding of the areas they will work in and what skills are involved.

The group is also working on the HCSW Band 2 to Band 3 programme to ensure HCSW roles and responsibilities match the national profile. It is expected to produce a detailed project plan by the end of January.

Conclusion

In conclusion, progress has been made in reducing nursing and midwifery vacancies at MKUH over the past six months. This has been achieved through various efforts such as international recruitment programmes, student nurse-to-staff nurse initiatives, and the nursing associate training programme. While progress has been made, healthcare support worker vacancies remain a challenge. The Trust has collaborated

with BLMK on a regional healthcare support worker recruitment campaign to address this. As a result, HCWS vacancies are expected to decrease by 40% in January 2024.

The inpatient nurse establishment review provides an updated position on the nursing workforce requirements to achieve optimal staffing levels in inpatient areas, the emergency department, and children's and young people's services. The review proposes changes to the nursing establishment on Ward 19, Ward 18, and Ward 22 in the Medical Division, Ward 20 in the Surgical Division, and Ward 5 in the Women and Children Division. The Emergency Department will also seek investment to enhance the skill mix, headroom, and leadership structure. The Trust will initiate data collection for the second nursing establishment review in January 2024.

Recommendation

The Trust Board is asked to receive this report and note the ongoing plans to provide safe staffing levels within nursing, midwifery, and AHP disciplines.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board	**Date :** January 2024
Report Title	Maternity Clinical Negligence Scheme for Trusts (CNST) sign off	**Agenda item Number:** 12
Lead Director	Yvonne Christley – Chief Nurse	
Report Author	Elaine Gilbert Divisional Chief Midwife	

Introduction	The CNST presentation and declaration form have been submitted to Trust Board as part of the sign off process for CNST Year 5. The presentation details the expected compliance for each safety action, this is supported by evidence files. The purpose of the paper is for board agreement and sign off, based on the evidence and detailed compliance. The CEO is required to discuss compliance with the ICB AO who is also required to sign the declaration form. The evidence has been submitted to the LMNS for review on the 20th December 2023.		
Key Messages to Note	CNST compliance is currently as detailed below: Safety Action 1 – Compliant Safety Action 2 – Compliant Safety Action 3 – Compliant Safety Action 4 – Compliant with workforce plans in place for neonatal medical work force and neonatal nursing workforce. Safety Action 5 –Complaint – SA 5 4d) where not compliant an action plan has been developed as required for CNST compliance Safety Action 6 – Compliant Safety Action 7 – Compliant Safety Action 8 – Compliant Safety Action 9 – Compliant Safety Action 10 –Compliant		
Recommendation (*Tick 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. Spending money well on the care you receive		
Report History			
Next Steps	Trust Board Confirmation of LMNS sign off		
Appendices / Attachments	CNST Trust Board Presentation Maternity Incentive Scheme – Board Declaration Form Maternity Incentive Scheme – Relaunch Guidance		

Milton Keynes University Hospital NHS Foundation Trust

Maternity Incentive Scheme (MIS) Year 5

Reporting period 30th May 2023 – 7th December 20223

TheMKWay

Year 5 Submission

Milton Keynes University Hospital NHS Foundation Trust

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form by 12 noon on 1 February 2024.

The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions.

The Trust Board declaration form must be signed and dated by the Chief Executive Officer (CEO) to confirm that:

1. The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions
2. There are no reports covering 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to the Trusts declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.).

In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' 5 evidence and declaration form.

The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

Overall Compliance to 10 safety actions CNST Year 5

Milton Keynes University Hospital NHS Foundation Trust

Anticipated compliance to 10 Safety Actions CNST Year 5		
1	Perinatal Review Tool	Compliant
2	Maternity Services Data Set (MSDS)	Compliant
3	Avoiding Term Admissions Into Neonatal Units (ATAIN)	Compliant
4	Medical Workforce	Compliant
5	Midwifery Workforce	Compliant
6	Saving Babies Lives Version 3 (SBLCB V3)	Compliant
7	Patient Feedback	Compliant
8	Multi-professional training	Compliant
9	Safety Champions	Compliant
10	Early notification scheme (HSIB)	Compliant

Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Milton Keynes University Hospital NHS Foundation Trust

1	Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death?	Yes
3	For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
4	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
5	Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	Yes
6	Were 60% of the reports published within 6 months of death?	Yes
11	Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
12	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety Action 1: **COMPLIANT** (Actions 7 -10 relating to IA – N/A)

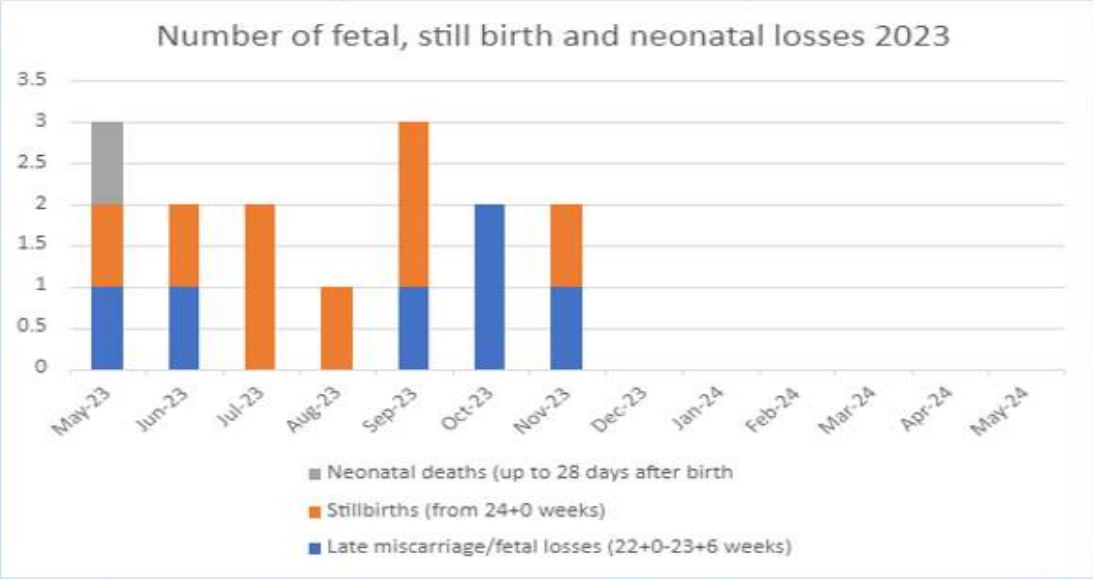
NHS
Milton Keynes University Hospital
NHS Foundation Trust

PMRT

Safety action - 1

NHS
Milton Keynes University Hospital
NHS Foundation Trust

All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death.	A minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.	For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	Number of MNSI/SI cases that were not closed within 6 months
15	100%	100%	100%	1



Themes within PMRT

- There were no MBRRACE or PMRT cases in December

In July there was a TOP at 29+1 which is not PMRT. In November there was a TOP at 24+3 which is not PMRT

Safety Action 2: Are you submitting data to the Maternity Data Set (MSDS) to the required standard ?

Milton Keynes University Hospital NHS Foundation Trust

1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	N/A
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	Yes

Safety Action 2: **COMPLIANT**

***MKUH suspended CoC and therefore criteria 4 (ii) is not applicable for year 5.**

Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Milton Keynes University Hospital NHS Foundation Trust

a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		
1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.		
3	Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks?	Yes
4	Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks?	Yes
5	Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan?	Yes
6	Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?	Yes
c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.		
7	Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring?	Yes
8	OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation?	N/A

Safety Action 3: **COMPLIANT**

Transitional Care

Milton Keynes University Hospital NHS Foundation Trust

- Transitional Care pathway is audited monthly and reported through CSU.
- All term admissions to the Neonatal Unit are recorded on Badgernet.
- Monthly audits collect Transitional Care activity.
- Weekly ATAIN review meetings.
- Live ATAIN action plan and Transitional Care action plan in place.
- Progress with ATAIN action plan is shared through the Maternity Assurance Group and the maternity improvement workplan

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Milton Keynes University Hospital NHS Foundation Trust

Obstetric Medical Workforce

a) Obstetric medical workforce		
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity :		
1	a. Locum currently works in their unit on the tier 2 or 3 rota?	No
2	**OR** b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?	Yes
3	**OR** c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	N/A
4	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Yes
5	**OR** Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf	N/A
6	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	Yes
7	**OR** Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf	N/A
8	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person?	Yes
9	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	N/A

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Milton Keynes University Hospital NHS Foundation Trust

Obstetric Medical Workforce continued

Do you have evidence that the Trust position with the above has been shared:		
10	At Trust Board?	Yes
11	With Board level safety champions?	Yes
12	At LMNS meetings?	Yes

Anaesthetic Medical Workforce

b) Anaesthetic medical workforce		
13	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes
	The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)	

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Milton Keynes University Hospital NHS Foundation Trust

Neonatal Medical Workforce

c) Neonatal medical workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes?	No
15	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
16	LMNS?	Yes
17	ODN?	Yes

Neonatal Nursing Workforce

18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	No
19	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
20	LMNS?	Yes
21	ODN?	Yes

Safety Action 5: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Milton Keynes University Hospital NHS Foundation Trust

- Workforce plans for points 14 for the Neonatal Medical Workforce and 18 for the Neonatal Nursing Workforce of Safety Action 4 have been developed and approved by the LMNS.
- The Medical Neonatal workforce plans has also been shared with the TV-W neonatal network in December 2023.
- The workforce plans for neonatal nursing are mid to long term solutions and relate to training and development of current staff in post.

Safety Action 4: **COMPLIANT -** Compliant with workforce plans in place for neonatal medical work force and neonatal nursing workforce.

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Milton Keynes University Hospital NHS Foundation Trust

1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated	Yes
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. Can you provide evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating **100% compliance** with supernumerary labour ward co-ordinator status? The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.** If the failure to maintain supernumerary status is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard.	Yes

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Milton Keynes University Hospital NHS Foundation Trust

4	d) Have all women in active labour received one-to-one midwifery care?	No
5	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour?	Yes
6	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	Yes
7	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period?	Yes

- A detailed action plan (SA5 point 5) has been developed to ensure that compliance with 1:1 care can be achieved. This has been submitted as part of the required evidence for the CNST.
- 1 to 1 care in labour overall compliance is reported monthly though the governance report and monitored daily on the maternity safety huddles.
- 1 to 1 care in labour is between 99.3 - 100% and an action plan is in place.
- Supernumerary status of Band 7 Labour Ward Co-ordinator - action plan in place.
- Birth Rate Plus Workforce reports were completed in 2018 and 2021.The Trust is able to evidence midwifery staffing budget reflects establishment calculated in BR+, funding has been agreed.

Safety Action 5: **COMPLIANT -** SA 5 4d) where not compliant an action plan has been developed as required for CNST compliance.

Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Milton Keynes University Hospital NHS Foundation Trust

1	Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	Yes
2	Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool? Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Progress against locally agreed improvement aims. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.	Yes
3	Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall?	Yes
4	Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements?	Yes

- All elements of SBLCBv3 on a regular audit cycle to review compliance – all over 80% and action plan in place for element 5.
- Reduced quarterly care bundles this reporting period, all submitted to LMNS for oversight review and sign off December 2023.

Safety Action 6: **COMPLIANT**

TheMKWay

Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Milton Keynes University Hospital NHS Foundation Trust

1	Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan?	Yes
2	Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board?	Yes
3	Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions?	Yes
4	Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff?	Yes
5	Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support?	Yes
6	Can you provide the local MNVP's work plan and evidence that it is funded?	Yes
7	Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?	Yes
8	Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation?	Yes

Safety Action 7: **COMPLIANT**

Service User Feedback

Milton Keynes University Hospital NHS Foundation Trust

- Maternity Voices Partnership (MVP) Terms of Reference in place and minutes of MVP meetings available.
- Written confirmation provided that the service user chair is being renumerated.
- MVP workplan agreed and LMNS sign off confirmed.
- Written confirmation provided that out-of-pocket expenses can be claimed
- MVP workplan and communication plan includes direct focus on those from underrepresented communities including Black, Asian and Minority Ethnic backgrounds.
- MVP co-chairs commenced attending the monthly maternity governance meetings since August 2023.

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Milton Keynes University Hospital NHS Foundation Trust

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	A local training plan is in place for implementation of Version 2 of the Core Competency Framework	Yes
Can you evidence that the plan has been agreed with:		
2	Quadrumvirate?	Yes
3	Trust Board?	Yes
4	LMNS/ICB?	Yes
5	Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England?	Yes
6	Can you evidence service user involvement in developing training?	Yes
7	Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports?	Yes
8	Can you evidence that you promote learning as a multidisciplinary team?	Yes
9	Can you evidence that you promote shared learning across a Local Maternity and Neonatal System?	Yes

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Milton Keynes University Hospital NHS Foundation Trust

- Elements 10- 12 relate to Fetal monitoring relating to obstetric and midwifery staff.
- In all 3 elements the required level above of 90% compliance was achieved.

- Maternity emergencies and professional training meets all required elements 13-20.

- Elements 21 -25 relate to neonatal basic life support and all elements achieved the required standard of above 90%.
- Element 26 relates to the in house deliver of basic NLS updates by 31.03.2024 – which has been achieved

*Elements 27 and 28 are not applicable to MKUH as the required standards has been achieved.

Safety Action 8: **COMPLIANT**

MDT Training

Milton Keynes University Hospital NHS Foundation Trust

Approved maternity training plan mapped against core competency document in place

Training compliance reported monthly through governance report and 90% compliant in all areas required

Training

Milton Keynes University Hospital NHS Foundation Trust

12 Month Period December 2022 - December 2023

Actual figures						
PROMPT						
		Midwives	MSW/MCA	Obstetrician	Anaesthetists	Totals
N° of staff		164	30	38	36	268
Trained staff		162	28	38	34	262
Compliance		99%	93%	100%	94%	98%

PROMPT broken down by Obstetric group			
	Consultant	Reg/SHO	Totals
N° of staff	14	24	38
Trained staff	14	24	38
Compliance	100%	100%	100%

PROMPT broken down by Anaesthetic group			
	Consultant	Other	Totals
N° of staff	15	21	36
Trained staff	15	19	34
Compliance	100%	90%	94%

Actual figures			
Fetal Monitoring			
	Midwives	Obstetricians	Totals
N° of staff	164	35	199
Trained staff	161	35	196
Compliance	98%	100%	98%

Fetal monitoring broken down by Obstetric group			
	Consultants	Reg/SHO	Totals
N° of staff	13	22	35
Trained staff	13	22	35
Compliance	100%	100%	100%

Actual figures			
Gap/GROW & SFH -CTG -SBL			
	Midwives	Doctors	Totals
N° of staff	162	28	190
Trained staff	156	26	182
Compliance	96%	93%	96%

Actual figures						
Neonatal Life Support						
	Midwives	Paed Con	Paed other	ANNP	NNU	Total
N° of staff	164	12	37	4	4	221
Trained staff	153	12	35	4	4	208
Compliance	93%	100%	95%	100%	100%	94%

Safety Action 9: Can you demonstrate that there are robust processes in place to provide assurance to the board on maternity and neonatal safety and quality issues ?

Milton Keynes University Hospital NHS Foundation Trust

1	**Required Standard A.** **Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-**	Yes
2	Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues?	Yes
3	Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)? It must include: • number of incidents reported as serious harm • themes identified and action being taken to address any issues • Service user voice feedback • Staff feedback from frontline champions' engagement sessions • Minimum staffing in maternity services and training compliance	Yes
4	Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	Yes

*PQSM – Perinatal Quality Surveillance Model

Safety Action 9: Can you demonstrate that there are robust processes in place to provide assurance to the board on maternity and neonatal safety and quality issues ?

Milton Keynes University Hospital NHS Foundation Trust

Required standard B. **Have you submitted evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of:**		
5	The Trust Board?	Yes
6	LMNS/ICS/Local & Regional Learning System meetings?	Yes
7	Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff?	Yes
8	Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	Yes
9	**Required standard C.** **Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?**	Yes
10	Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit?	Yes
11	Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024?	Yes
12	Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?	Yes

Safety Action 9: **COMPLIANT**

Board Assurance of Maternity and Neonatal Safety and Quality

Milton Keynes University Hospital NHS Foundation Trust

- Safety champions pictures visible in clinical areas
- PQSM metrics reviewed monthly at CSU, MAG, Trust Board
- Monthly staff forum with board level maternity safety champions
- Safety concerns dashboard in place reported monthly and visible in clinical areas
- Safety champions support maternity team attendance at Maternity and Neonatal network meetings
- Maternity and Neonatal team actively engaged in the MatNeo improvement programme, including attendance at optimisation forums; patient safety network meeting
- Culture surveys used to inform improvement plans – action plan in place to demonstrate approach
- Maternity Improvement Workplan monitors improvement plans and workstreams

*PQSM – Perinatal Quality Surveillance Model

Safety Action 10:Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

Milton Keynes University Hospital NHS Foundation Trust

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes
2	Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023?	Yes
3	Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023?	Yes
	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:	
4	The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme	Yes
5	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	Yes
	Can you confirm that the Trust Board has:	
6	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution?	Yes
7	Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme?	Yes
8	Sight of evidence of compliance with the statutory duty of candour?	Yes

Safety Action 10: **COMPLIANT**

Women's External open investigations

Maternity

Safety action 10

Milton Keynes University Hospital NHS Foundation Trust

Incident date	Final report received from HSIB	Incident	Report type	Current status	Improvement plan update	Information about HSIB/EN provided to the family	Written DoC and HSIB consent
05/08/23		Therapeutic cooling	MNSI	Ongoing Investigation	Ongoing	Yes	Yes
21/09/23		IUD 40+1 early labour	MNSI	Ongoing Investigation	Ongoing	Yes	Yes
26/09/23		Therapeutic cooling	MNSI	Ongoing Investigation	Ongoing	Yes	Yes
05/11/2023		Therapeutic cooling	MNSI	Ongoing Investigation	Ongoing	Yes	Yes
27/11/2023		Maternal Death	MNSI	Ongoing Investigation	Ongoing	Yes	Yes

Number of cases which met the criteria for referral to MNSI 06/12/22 – 07/12/23	Number of cases referred to MNSI 06/12/22 – 07/12/23	Number of cases accepted by MNSI 06/12/22– 07/12/23	Number of cases declined by MNSI or Family 06/12/22 – 07/12/23
8	8	5	3

Conclusion

Milton Keynes University Hospital NHS Foundation Trust

Section A : Maternity safety actions - Milton Keynes Hospital NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	10	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	6	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	7	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	15	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	0	0	0
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	4	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	8	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	27	0	1	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	12	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes	8	0	0	0	0

Summary of all maternity safety actions met

TheMKWay

Milton Keynes University Hospital
NHS Foundation Trust

Questions ?

TheMKWay

Maternity incentive scheme - Guidance

Trust Name	**Milton Keynes Hospital NHS Foundation Trust**
Trust Code	**T164**

This document must be used to complete your trust self-certification for the maternity incentive sche which have not been met. Please select your trust name from the drop down menu above. **Your tru please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive sche

The Board declaration form must not include any narrative, commentary, or supporting documents. E NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate con incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The in tab D which is the board declaration form.

Tab B - safety action summary sheet - This will provide you information on your Trust's progress ir Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for a

Tab D - Board declaration form - This is where you can track your overall progress against compli protected and fields cannot be altered manually. If there are anomalies with the data entered, then c checking and verifying data before it is discussed with the trust board, commissioners and before sul

Upon completion of the following processes please add an electronic signature into the allocated spa of the ICS will be required in Tab D as outlined in order to declare compliance stated in the board de to confirm that the declaration form has been submitted to Trust Board with an accompanying joint p Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services and two signatur 2022/23 financial year or 2023/24 that relate to the provision of maternity services that may subsequ should be brought to the MIS team's attention before 1 February 2024.

If you are unable to add an electronic signature, the board declaration form can be printed, signed th

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhs** Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-f

Submissions for the maternity incentive scheme must be received no later than 12 noon on 1 **Febru** You are required to submit this document signed and dated. Please do not send evidence to NHS R

Version Name: MIS_SafetyAction_2024

me safety actions and a completed action plan must be submitted for actions
ust name will populate each tab. If the trust name box is coloured pink

me safety actions excel spreadsheet. **Please read the guidance carefully.**

Evidence should be provided to the Trust Board only, and will not be reviewed by

mpliance as detailed within each condition of the scheme with each maternity
nformation which has been populated in this tab, will automatically populate onto

n completing the board declaration form and will outline on how many
D.

ny safety actions not achieved.

ance with the maternity incentive scheme safety actions. This sheet will be
omments will appear in the validations column (column I) this will support you in
bmission to NHS Resolution.

aces within this document. Two electronic signatures of the Trust's CEO and AO
claration form with the safety actions and their sub-requirements, one signature
resentation detailing position and progress with maternity safety actions by the
es to declare that there are no external or internal reports covering either
ently provide conflicting information to your Trust's declaration. Any such reports

en scanned to be included within the submission.

r.mis@nhs.net

for-trusts/maternity-incentive-scheme/

ary 2024 to nhsr.mis@nhs.net
esolution.

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?
From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death?	Yes
3	For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
4	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
5	Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	Yes
6	Were 60% of the reports published within 6 months of death?	Yes
7	Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales?	N/A
8	Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period.	N/A
9	If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted?	N/A
10	PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted?	N/A
11	Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
12	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	N/A
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	Yes

Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		
1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.		
3	Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks?	Yes
4	Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks?	Yes
5	Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan?	Yes
6	Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?	Yes
c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.		
7	Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring?	Yes
8	OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation?	N/A

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity :		
1	a. Locum currently works in their unit on the tier 2 or 3 rota?	No
2	**OR** b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?	Yes
3	**OR** c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	N/A
4	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Yes
5	**OR** Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf	N/A
6	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	Yes
7	**OR** Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf	N/A
8	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person?	Yes
9	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	N/A

Do you have evidence that the Trust position with the above has been shared:		
10	At Trust Board?	Yes
11	With Board level safety champions?	Yes
12	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
13	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes
	The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)	
c) Neonatal medical workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes?	No
15	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
16	LMNS?	Yes
17	ODN?	Yes
d) Neonatal nursing workforce		
18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	No
19	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
20	LMNS?	Yes
21	ODN?	Yes

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated	Yes
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes

3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. Can you provide evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating **100% compliance** with supernumerary labour ward co-ordinator status? The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.** If the failure to maintain supernumerary status is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard.	Yes
4	d) Have all women in active labour received one-to-one midwifery care?	No
5	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour?	Yes
6	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	Yes
7	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period?	Yes

Safety action No. 6

Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	Yes
2	Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool? Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Progress against locally agreed improvement aims. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.	Yes
3	Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall?	Yes
4	Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements?	Yes

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan?	Yes
2	Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board?	Yes
3	Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions?	Yes
4	Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff?	Yes
5	Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support?	Yes
6	Can you provide the local MNVP's work plan and evidence that it is funded?	Yes
7	Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?	Yes
8	Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation?	Yes

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2022 to 1st December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	A local training plan is in place for implementation of Version 2 of the Core Competency Framework	Yes
Can you evidence that the plan has been agreed with:		
2	Quadrumvirate?	Yes
3	Trust Board?	Yes
4	LMNS/ICB?	Yes
5	Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England?	Yes
6	Can you evidence service user involvement in developing training?	Yes
7	Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports?	Yes
8	Can you evidence that you promote learning as a multidisciplinary team?	Yes
9	Can you evidence that you promote shared learning across a Local Maternity and Neonatal System?	Yes
Can you demonstrate the following at the end of 12 consecutive months ending December 2023? 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted. If this is the case, please select 'Yes'		
Fetal monitoring and surveillance (in the antenatal and intrapartum period)		
10	90% of obstetric consultants?	Yes
11	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)?	Yes
12	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres?	Yes
Maternity emergencies and multiprofessional training		
13	90% of Obstetric consultants?	Yes

14	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	Yes
15	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives?	Yes
16	90% of maternity support workers and health care assistants attend the maternity emergency scenarios training?	Yes
17	90% of obstetric anaesthetic consultants?	Yes
18	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota?	Yes
19	Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care?	Yes
20	Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area **or** does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members?	Yes
Neonatal basic life support		
21	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
22	90% of neonatal junior doctors (who attend any births)?	Yes
23	90% of neonatal nurses (Band 5 and above who attend any births)?	Yes
24	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
25	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	Yes
26	All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024.	Yes
27	Have you declared compliance for any of Q10-Q25 above with 80-90%?	No
28	If you are declaring compliance for any of Q10-Q25 above with 80-90%, can you confirm that an action plan has been approved by your Trust Board to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period?	N/A

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	**Required Standard A.** **Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-**	Yes
2	Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues?	Yes
3	Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)? It must include: • number of incidents reported as serious harm • themes identified and action being taken to address any issues • Service user voice feedback • Staff feedback from frontline champions' engagement sessions • Minimum staffing in maternity services and training compliance	Yes
4	Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	Yes
Required standard B. **Have you submitted evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of:**		
5	The Trust Board?	Yes
6	LMNS/ICS/Local & Regional Learning System meetings?	Yes
7	Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff?	Yes

8	Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	Yes
9	**Required standard C.** **Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?**	Yes
10	Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit?	Yes
11	Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024?	Yes
12	Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes
2	Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023?	Yes
3	Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023?	Yes
	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:	
4	The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme	Yes
5	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	Yes
	Can you confirm that the Trust Board has:	
6	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution?	Yes
7	Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme?	Yes
8	Sight of evidence of compliance with the statutory duty of candour?	Yes

Section A : Maternity safety actions - Milton Keynes Hospital NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes

8	Can you evidence the following 3 elements of local training plans and ‘in-house’, one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes

Section B : Action plan details for Milton Keynes Hospital NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity Incentive Scheme - Board declaration form

Trust name	**Milton Keynes Hospital NHS Foundation Trust**
Trust code	**T164**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2023/24) or the previous financial year (2022/23)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.
* If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Milton Keynes Hospital NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
For and on behalf of the board of	Milton Keynes Hospital NHS Foundation Trust
Name:	
Position:	
Date:	

NHS Resolution

Maternity Incentive Scheme – year five

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

V1.1 July 2023

Contents

Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year five: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by **12 noon** on **1 February 2024** and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Trust Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
    - There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **1 February 2024**.
- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions'

evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution

- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of
  MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions, then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution
  Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by **1 February 2024** at **12 noon** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.

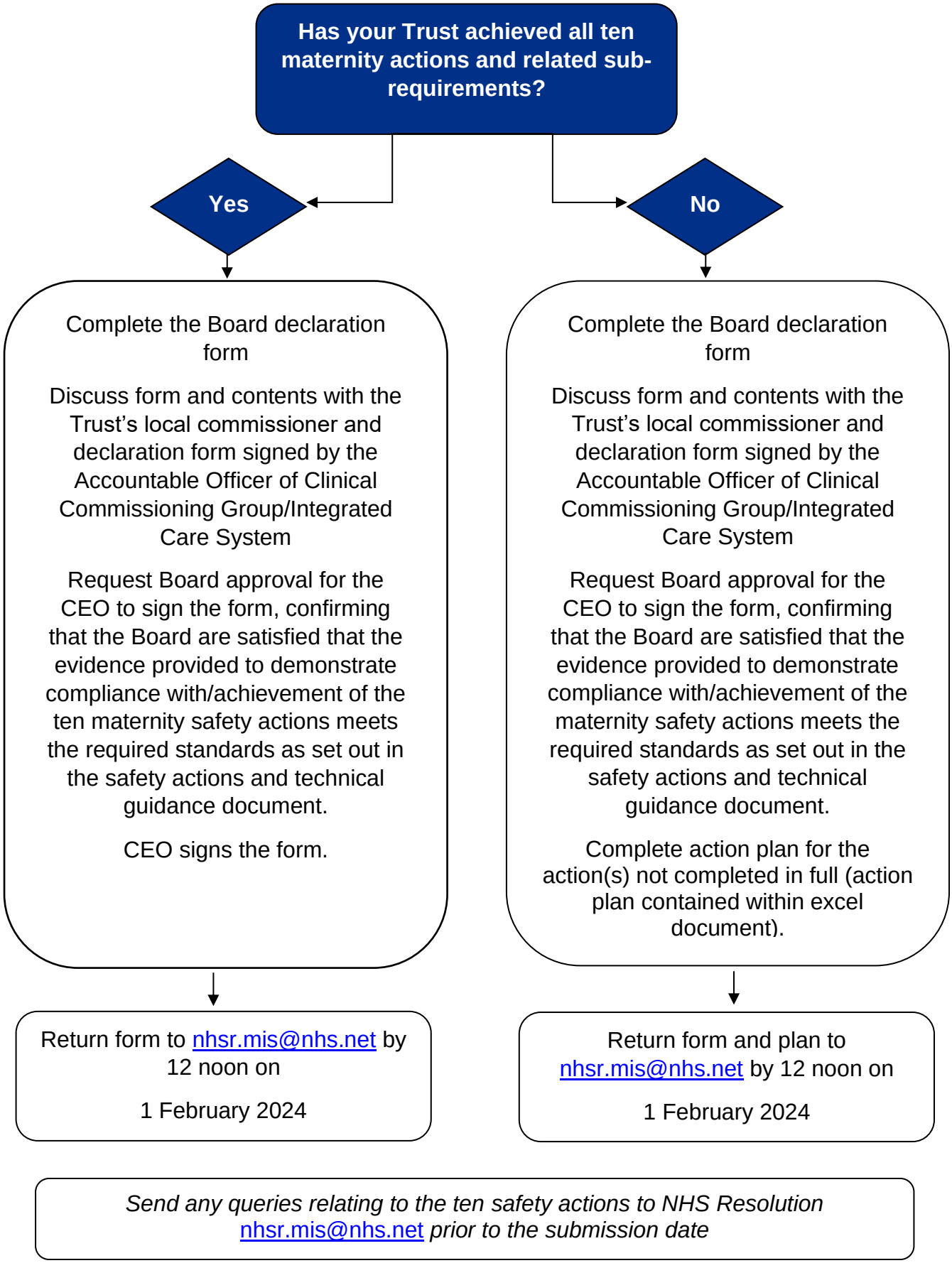
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The Board declaration form will be available on the MIS webpage at a later date.
- Trusts are reminded to retain all evidence used to support their position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described above) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution nhsr.mis@nhs.net prior to the submission date.
- The Board declaration form must be sent to NHS Resolution nhsr.mis@nhs.net between **25 January 2024** and **1 February 2024** at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from submission date.
- Submissions and any comments/corrections received after **12 noon** on **1 February 2024** will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
    - alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation
    - technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- NHS Resolution clinical advisors will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Further detail on the results publication, appeals window dates and payments process will be communicated at a later date.

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 1 February 2024 to NHS Resolution nhsr.mis@nhs.net. The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.


Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
Return form to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Return form and plan to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Send any queries relating to the ten safety actions to NHS Resolution nhsr.mis@nhs.net prior to the submission date

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard	a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from **30 May 2023,** MBRRACE-UK surveillance information should be completed within one calendar month of the death. b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30 May 2023** onwards. c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**
Minimum evidential requirement for Trust Board	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter from **30 May 2023** that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**12 noon** on **1 February 2024**

Technical guidance for safety action 1

Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the MBRRACE-UK/PMRT system to track your notifications and reviews: www.npeu.ox.ac.uk/pmrt/faqsmis; these FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk.

Technical Guidance **Guidance for SA 1(a) – notification and completion of surveillance information**	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that a single notification portal (SNP) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through the SNP and this information will be passed to MBRRACE-UK. It will then be necessary for reporters to log into the MBRRACE-UK surveillance system to provide the surveillance information and use the PMRT.
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from **30 May 2023** onwards must be notified to MBRRACE-UK within seven working days.
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission

	to CDOP. This will also be the required route for providing additional information about the death required by both CDOPs and the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months
Are there any exclusions from completing the surveillance information?	If the surveillance form needs to be assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.
Guidance for SA1(b) – parent engagement	
We have informed parents that a local review will take place and they have been asked if they have any reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' perspectives and questions can be considered during the review this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.

Parents have not responded to our messages and therefore we are unable to discuss the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will also be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
Guidance for SA1(c) – conducting reviews	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: • All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.
What happens when an HSIB investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the MIS standards for these babies may therefore be impacted by time frames beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place, and this will be accounted for in the external validation process.

What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: FQ
What is meant by "reviews should be completed to the draft report stage"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details of assistance in using the PMRT to complete a review.
What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the unit who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
What should we do if our post-mortem service has a turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.

What is review assignment?	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided.
How does 'assigning a review' impact on safety action 1, especially on starting a review?	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the external validation process.
What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between **30 May 2023** and **7 December 2023** you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
What deaths should we review outside the relevant time period for the safety action validation process?	Trusts should review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 5 MIS requirements.
Guidance for SA1(d) – Quarterly reports to Trust Boards	
Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period, within the PMRT for user-defined time periods. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.
Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'.

	Please note that these reports will only show summaries, issues and action plans for reviews **that have been published** therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – Technical issues and updates	
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on the PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action 1, will be communicated via NHS Resolution email and will also be included in the PMRT 'message of the day'.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023. 2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: **Midwifery Continuity of carer (MCoC)** **Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be published in October 2023.

	If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information). 4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. 5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.
Minimum evidential requirement for Trust Board	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at 12 noon

Technical guidance for safety action 2

Technical guidance	
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? • **Proportion of babies born at term with an Apgar score <7 at 5 minutes** • **Women who had a postpartum haemorrhage of 1,500ml or more** • **Women who were current smokers at delivery** • **Women delivering vaginally who had a 3rd or 4th degree tear** • **Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** • **Caesarean section delivery rate in Robson group 1 women** • **Caesarean section delivery rate in Robson group 2 women** • **Caesarean section delivery rate in Robson group 5 women**	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2023 data for these CQIMs. Due to this, Trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If maternity services have suspended Midwifery Continuity of Carer (MCoC) pathways, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 3i. If your Trust has suspended all MCoC pathways, criteria 3ii is not applicable and does not need to be completed. If your Trust is continuing with some provision of MCoC pathways, then criteria 3ii does still apply.

Will my Trust fail this action if women choose not to receive continuity of carer?	No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output. If women choose not to be placed onto a MCoC pathway, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102.
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS England specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool
For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 3?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement, and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for the scheme. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics in criteria 3.

The monthly publications and Maternity Services DashBoard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics The scores for each data quality criteria can be found in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series
The monthly publications and national Maternity Services DashBoard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Required standard	a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies **equal to or greater than 37 weeks**. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.
Minimum evidential requirement for Trust Board	**Evidence for standard a) to include:** Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.
	Evidence for standard b) to include: • Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. • Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.

	• Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan.
	Evidence for standard c) to include: Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring **OR** An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**30 May 2023** to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process from years three and four of the maternity incentive scheme was to inform future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review. This should be in place and maintained in order to inform ongoing capacity planning of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the Operational Delivery Network (ODN), LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in ATAIN reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
We have undertaken some reviews for term admissions to NICU, do we need to undertake more and do all babies admitted to the NNU need to be included?	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the Avoiding Term Admissions into Neonatal Units (ATAIN) work to date. The expectation is that reviews have been continued from year 4 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 4 of the 2022/23 financial year (beginning January 2023). This may mean that some of the audit is completed retrospectively. We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies **equal to or greater than 37 weeks** to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all admissions should be included, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were admitted with jaundice and 35% of babies were admitted with hypothermia then focus on these two cohorts of babies.

	In addition to this, the number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues and the number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
What do you mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year and should cover the period of the MIS **30 May 2023 – 7 December 2023**.
What should the Transitional Care audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template; however, the audit needs to include aspects of the local pathway. ATAIN-CASE-NOTE-REVIEW-PROFORMA-Revised-2022-converted.pdf We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
How long have the neonatal safety champions been in place for?	Trust Board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/

	https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk)

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	a) **Obstetric medical workforce** 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document:

	‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’ into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. **b) Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) **c) Neonatal medical workforce** The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements **have not been met** in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). **d) Neonatal nursing workforce** The neonatal unit meets the BAPM neonatal nursing standards. If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed

	and include new relevant actions to address deficiencies. If the requirements **had been met** previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS. 3) Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working

	as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations. **NB**. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG 4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS. **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Obstetric medical workforce** 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 **Anaesthetic medical workforce** Trusts to evidence position by 7 December 2023 at 12 noon **Neonatal medical workforce** A review has been undertaken of any 6 month period between **30 May 2023 – 7 December 2023** **a) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 5 reporting period **30 May 2023 – 7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2023. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to short term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to long term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2023 and prior to submission to the Trust Board and have a plan to address any shortfalls in compliance.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long term locums are employed who are not fully supported/supervised?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to long term locums?	Safe staffing | RCOG

	All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors acting down?	Trusts should provide documentary evidence of standard operating procedures and their implementation Evidence of implementation/compliance could be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should produce a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Trusts cannot self-certify if they have no evidence of any standard operating procedures by **October 2023**. They can self-certify if they have been unable to achieve appropriate compensatory rest in individual circumstances such as excessive staffing pressure have prevented the doctor accessing this. They should, however, demonstrate that they have an action plan to ensure future compliance and provide assurance to the Board that this is place.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to consultant attendance out of hours?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this element of safety action 4 if	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans

consultants have not attended clinical situations on the mandated list?	implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net and RCOG	

Anaesthetic medical workforce

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	**A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.**

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication whether the standards not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps. This action plan should be submitted to the LMNS and ODN.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	

NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1** Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3. NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice. **Tier 2** A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP. NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone. NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.

LNU **Local Neonatal Unit**	**Tier 1** At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7. In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework. **Tier 2** An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week. LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7. **Tier 3** Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit. LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually. No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training**.**

SCU **Special Care Unit**	**Tier 1** A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. **Tier 2** A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit. **Tier 3** In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology).
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 5 reporting period.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021). A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance	
Neonatal nursing workforce standards and action	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

	• Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.
	
	  ○ The midwife to birth ratio
	
	  ○ The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
	
	• Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	30 May 2023 – 7 December 2023
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at **12 noon**

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637 https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to

	midwives at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 5 of MIS.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required standard	1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. 2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.
Minimum evidential requirement for Trust Board	1) The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. A new implementation tool is now available to help maternity services to track and evidence improvement and compliance with the requirements set out in version three. The tool is based on the interventions, key process and outcome measures identified within each element, and is available at https://future.nhs.uk/SavingBabiesLives Providers should use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, **providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.** These percentages will be calculated within the national implementation tool. 2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust, using the implementation tool and includes the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.

	• Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/ The implementation tool is available at https://future.nhs.uk/SavingBabiesLives and includes a technical glossary for all data items referred to in MSDS Additional resources are in production and will be advertised on this page. Any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net Some data items are or will become available on the National Maternity Dashboard or from NNAP Online For any other queries, please email nhsr.mis@nhs.net
What is the rationale for the change in evidential requirements to SA6 in Year 5?	The broad principles that will apply to the implementation of the standards detailed in the Saving Babies' Lives Care Bundle (version 3) are: The use of the implementation tool will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle (for some elements this may only require evidence of a protocol, process, or appointed post). These data will form the basis of compliance with safety action 6 of this version of the maternity incentive scheme. This approach acknowledges the increased number and/or size of elements in this new version of the care bundle. The indicators for each of the six elements are set out below. Data relating to each of these indicators will need to be provided via the national implementation tool. ***Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and/or Neonatal System e.g Badgernet and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding.***

What are the indicators for Element 1	*Process Indicators* 1a. Percentage of women where there is a record of: 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment 1b. Percentage of smokers* that have an opt-out referral at booking to an in-house/in-reach tobacco dependence treatment service. 1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date. *Outcome Indicators* 1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. 1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks. *a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). **Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.
What are the indicators for Element 2	*Process Indicators* 2a. Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking. (This should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.) 2b. Percentage of pregnancies where a Small for Gestational Age (SGA) fetus (between 3rd to <10th centiles) is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital. 2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT). *Outcome Indicators*

	2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). 2e. Percentage of live births and stillbirths >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected.
What are the indicators for Element 3	*Process Indicators* 3a. Percentage of women who attend with Reduced Fetal Movements (RFM) who have a computerised Cardiotocograph (CTG). 3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan by the next working day to assess fetal growth. *Outcome Indicators* 3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. 3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation.
What are the indicators for Element 4	*Process Indicators* 4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors, and situational awareness. 4b. Percentage of staff who have successfully completed mandatory annual competency assessment. 4c. Fetal monitoring lead roles appointed. *Outcome Indicators* 4d. The percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 2018[48].

What are the indicators for Element 5	*Process Indicators* 5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU). 5b. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 5c. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. 5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. 5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. 5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. 5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. 5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (5a – 5g above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation). *To minimise the need for local data collection to support these improvements the formal collection of process measure data can be restricted to the seven interventions listed in this section, the use of volume targeted ventilation and caffeine is recommended but these data are not currently recorded or presented with national datasets. In addition, the gestational limits for some of the indicators and/or the groups studies have been adjusted to align with current nationally collected data (e.g., data on babies born only below 34 weeks or data on the number of babies*

	receiving antenatal corticosteroids rather than the number of mothers) *Outcome Indicators* **5i. Mortality to discharge in very preterm babies** (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner). **5j. Preterm Brain Injury** (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: ✓ Germinal matrix/ intraventricular haemorrhage ✓ Post haemorrhagic ventricular dilatation ✓ Cystic periventricular leukomalacia 5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was a relevant issue. 5l. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: ✓ In the late second trimester (from 16+0 to 23+6 weeks). ✓ Pre-term (from 24+0 to 36+6 weeks).
What are the indicators for Element 6	*Process Indicators* 6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). 6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.

	6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. 6d. Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. 6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities, and availability of expertise. *Outcome Indicators* 6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashboard (aiming for >95% of women). 6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women). Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.
What considerations need to be made to ensure timely submission of data to evidence implementation and compliance with locally agreed progress measures?	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. MSDS does not capture all process and outcome indicators given in the care bundle. A summary of this appears in the technical appendix for version 2 of the care bundle, available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/tools-and-guidance

	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.
Would a Trust be non-compliant if <60% of smokers set a quit date?	As stated in SA6, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. The implementation tool will set out the evidence requirement for demonstrating compliance with each intervention. Where element process and outcome measures are listed in the evidence requirement, a performance threshold is recommended, but this is for agreement between a provider and their ICB in view of local circumstances.
The SBLCBv3 that was published on the 31st May 2023 included a typo in Appendix D Figure 6 with BMI as >18.5kg/m and it is not clear what "other features" mean	This has now been amended and states **<18.5kg/m** with further clarity provided regarding "other features".
How do we provide evidence for the interventions that have been implemented?	The evidence requirements for each intervention are set out within the implementation tool. You will need to verify that you have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBLCB eLearning for Health modules is currently being updated in line with the latest iteration, Version 3 of the Care Bundle and will include a new section to support implementation of element 6. We have asked for the ultrasound element to be reviewed for its relevance, this was developed separately, and we will make sure the completion of the e learning is focussed on elements 1-6.
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at **12 noon**

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Required standard	1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. 2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. 3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.
Minimum evidential requirement for Trust Board	**Evidence should include:** • Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. • The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.
Validation process	Self-certification to NHS Resolution using the Board declaration form.

What is the relevant time period?	Trusts should be evidencing the position as **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at 12 noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people, and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality, and experience of maternity and neonatal care.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What advice is there for Maternity and Neonatal Voices Partnership (MNVP) leads when engaging and prioritising hearing the voices of neonatal and bereaved service users, and what support or training is in place to support MNVP's?	MNVPs should work in partnership with local specialist voluntary, community, and social enterprise (VCSEs) with lived experience to gather feedback. Engagement needs to be accessible and appropriate, particularly for neonatal and bereaved families. It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided. MNVPs can also work in collaboration with their trust bereavement leads to ensure adequate support is in place for themselves and the families they may engage with. Attendance at the trust training could be beneficial.
When will the MNVP guidance be published?	We are working with our stakeholders to publish the MNVP guidance as soon as possible. As it is not yet published, it is acknowledged that there may not be enough time ahead of the reporting period for full implementation of all the requirements of the MNVP guidance. Where an element of the guidance is not yet fully implemented, evidence must be presented that demonstrates progress towards full implementation within 12 months.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required standard and minimum evidential requirement	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review. It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1

Technical guidance for safety action 8

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A **training plan** should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. NHS England » Core competency framework version two Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.
How will the 90% attendance compliance be calculated?	The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups by the end of the 12 month period

Where can I find the Core Competencies Framework and other additional resources?	• https://www.england.nhs.uk/publication/core-competency-framework-version-two/
	• Includes links to the documents:
	  ○ Core competency framework version two: Minimum standards and stretch targets
	  ○ 'How to' guide - a resource pack to support implementing the Core Competency Framework version two
	  ○ Core competency framework: training needs analysis
	• NHS England V1 of the Core Competency Framework https://www.england.nhs.uk/publication/core-competency-framework/
	• https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth

What training should be included to meet the requirements of the Core Competency Framework Version 2?	All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles: 1. Service user involvement in developing and delivering training. 2. Training is based on learning from local findings from incidents, audit, service user feedback,

	and investigation reports. This should include reinforcing learning from what went well. 3. Promote learning as a multidisciplinary team. Promote shared learning across a Local Maternity and Neonatal System.
Which maternity staff should be included for Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor) • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees
Which maternity staff should be included for Module 3: Maternity emergencies and multiprofessional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants. • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota. • Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) **who contribute to the obstetric rota.**

	• Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 5 compliance assessment • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 5 compliance • At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff
Does the multidisciplinary emergency scenarios described in module 3 have to be conducted in the clinical area?	At least one emergency scenario needs to be conducted in the clinical area or at point of care. You need to ensure that 90% of your staff attend a minimum of one emergency scenario that is held in the clinical area, but not all of the scenarios have to be based in a clinical area.
Which staff should be included for Module 6: Neonatal basic life support?	Staff in attendance at births should be included for Module 6: Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. The staff groups below are not required to attend neonatal basic life support training: • All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). • Local policy should determine whether maternity support workers are included in neonatal basic life support training.

I am a NLS instructor, do I still need to attend neonatal basic life support training?	No, if you have taught on a course within MIS year 5 you do **not** need to attend neonatal basic life support training
I have attended my NLS training, do I still need to attend neonatal basic life support training?	No, if you have attended a course within MIS year 5 you do **not** need to attend neonatal basic life support training as well.
Which members of the team can teach basic neonatal life support training and NLS training?	Registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates. A detailed response to this can be found on the CCF NHS Futures page CCF NHS Futures page - FAQ
What do we do if we do not have enough instructors who are trained as an NLS instructor and hold the GIC qualification?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your Local Maternity and Neonatal System (LMNS) to explore sharing of resources. There may be difficulty in resourcing qualified trainers. Units experiencing this must provide evidence to their trust board that they are seeking mitigation across their LMNS and an action plan to work towards NLS and GIC qualified status by 31st March 2024. As a minimum, training should be delivered by someone who is up to date with their NLS training.
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined.
How do we involve services users in developing and <u>delivering</u> training?	Please refer to the "How To" guide for ideas on how to involve service users in the developing and delivering of training. This is **Principle 1** of the CCFv2 that recommends MNVP leads could be a member of the multidisciplinary educational teams (MET) to support the planning and selection of themes/local learning requirements to reflect in the training. Ways in which service users and service user representatives can support the delivery of training include with video case studies, inviting service users to tell their story or inviting charitable/support organisations for example local Downs Syndrome groups; LGBTQIA+ Communities; or advocates for refugees.

	NHS England will be sharing examples of practice over the year and on their NHS Futures page.
The TNA suggests periods of time required for each element of training, for example 9 hours for fetal monitoring training. Is this a mandated amount of time?	The TNA has been inputted with **example** times to demonstrate how the calculations are made for the backfill of staff that is required to put a training plan in place. The hours for each element of training can be flexed by the individual trust in response to their own local learning needs.
Do all the modules within the CCF require a multidisciplinary attendance?	Multidisciplinary team working has an evidence-base and has been highlighted in The Kirkup Report (2022). Key Action 3 (Flawed Team working) was a significant finding with the recommendation to improve teamworking with reference to establishing common purpose, objectives, and training from the outset. It is therefore a requirement that there is a strong emphasis on multidisciplinary training throughout the modules in response to local incidents. The staff groups within the multidisciplinary teams being trained may also vary, depending on the incident/emergency being covered.

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required standard	a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings. c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.
Minimum evidential requirement for Trust Board	**Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:** • Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. • Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). • To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need. **Evidence for point b)** • Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions

	must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting. **Evidence for point c):** Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Time period for points a and b)** • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st December 2023. • The expectation is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023. • The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff engagement sessions are visible to both maternity

	and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than the 17th July 2023. • Evidence that a review of the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. This should continue to be undertaken quarterly as detailed in MIS year 4. **Time period for points c)** • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have **registered** to the dedicated FutureNHS workspace to access the resources available no later than 1 August 2023. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of quarterly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 2 meetings held by 1 February 2024
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) Measuring culture in maternity services: Safety Culture Programme for Maternal and neonatal services: https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board safety champions to access the culture and leadership

	programme, view wider resources and engage with a community of practice to support them in their roles. The Perinatal Culture and Leadership Programme - Maternity Local Transformation Hub - Maternity (future.nhs.uk) is a dedicated space for NHS England's Perinatal Culture and Leadership Programmes, with resources for senior leaders and their teams to support local safety culture work.

Technical guidance for safety action 9

Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: • Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board. • Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician.
What do we need to include in the dashBoard presented to Board each month?	The dashboard can be locally produced, based on a minimum data set as set out in the Board level measures. It must include the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three and four requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 1 July 2023.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.

What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here 2021 Scorecards launch - NHS Resolution https://resolution.nhs.uk/2020/10/27/claims-scorecards-for-2020/
What are the expectations of the Board safety champions in relation to quality improvement work undertaken by the maternity and neonatal quality improvement programme?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will be involved in the Perinatal Culture and Leadership Programme. As part of this programme every service will be undertaking work to meaningfully understand the culture of their services. This diagnostic will either be a SCORE culture survey or an alternative as agreed with the national NHSE team. It is expected that diagnostic findings are shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings.
What if our maternity and neonatal services are not undertaking the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture is a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work.
What are the expectations of the NED and Exec Board safety champion in relation to	As detailed in previous years MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provide an opportunity to share

their support for the Perinatal Culture and Leadership Programme (PCLP), culture surveys and ongoing support for the Perinatal 'Quad' Leadership teams? / What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal 'Quad' Leadership teams?	safety intelligence, examples of best practice and identified areas of challenge. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive. As a minimum the content should cover: - Learning from the Perinatal Culture and Leadership Development Programme so far - Plans to better understand their local culture. This will be use of the SCORE culture survey, or suitable alternative as agreed by the national NHS England team. - Updates on the SCORE survey, or alternative when undertaken. - Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, a formal report following this work should be presented at Board by the Perinatal leadership team. Progress with interventions relating to culture improvement work, and any further support required from the Board
Clarification as to evidence required to meet the standard: *Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.*	The NED and Exec Board Safety Champion will be able to evidence they have registered on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace through minutes of a trust board meeting providing confirmation of specific resources accessed and how this has been of benefit. This will be reported as part of the board submission to NHS Resolution.
How often should the Board Safety Champions be meeting and engaging with the perinatal 'Quad' team?	Meetings between the Board Safety Champion(s) and Quad member(s) should be occurring a minimum of quarterly. We would expect a minimum of two meetings during this reporting period.
Who is expected to have undertaken the Perinatal Culture and Leadership Quad programme?	The expectation is that the senior perinatal leadership team (the Quad) have undertaken the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the

	DoM/HoM, clinical lead / CD for obstetrics, clinical lead for neonates and the operational manager.
Is there an expectation that the board safety champions have undertaken the programme?	The Board Safety Champions should be supporting the Quad and their work as part of the PCLP, but there is no expectation for them to attend the programme.
Evidence that a monthly review – Most Trust meet bi-monthly (every other month) & are unable to meet this requirement	A review must be undertaken at every board meeting. If this is bi-monthly that will be sufficient, but this is the minimum requirement.
Examples have been requested for how to review the data from scorecards	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historic claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historic themes re-emerged. An example is now available from the MIS team at NHS Resolution, and staff are happy to talk through this process if it is helpful.
The perinatal quality surveillance model requires review in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife to provide evidence of trust-level intelligence being shared and actions reported on areas of concern. This needs to happen before 1st July and therefore does not give trusts enough time to carry out this review	The expectation is that this process should already be in place as it was a requirement in previous years, with the year 4 requirement for this to be in place by 16th June 2022. However, in recognition of the challenges of embedding a new quality surveillance model the timeframe of the 1st July has been amended to 1st December 2023 to allow additional time for trusts.
Clarification as to what constitutes a trust board, can sub committees be categorised as a board?	This refers solely to the Board of the trust, and it is a requirement that the board oversees the quality of their perinatal services at every meeting.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) *(known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023)* and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Required standard	A) Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to **7 December 2023.** B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until **7 December 2023**. C) For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB/MNSI and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB/MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's

	involvement, completion of this will also be monitored, and externally validated.
What is the relevant time period?	Reporting to HSIB – from 6 December 2022 to **7 December 2023** Reporting period to HSIB **and** to NHS Resolution – from 6 December 2022 to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon

Technical guidance for Safety action 10

Technical guidance	
Where can I find information on HSIB?	Information about HSIB/ MNSI and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/ From October 2023 this website will no longer be available and the HSIB maternity programme will be hosted by the CQC. Further details will be circulated once available.
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website: • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB/MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or] • Was therapeutically cooled (active cooling only) [or] • Had decreased central tone AND was comatose AND had seizures of any kind. Once HSIB/MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
What is the definition of labour used by HSIB and EN?	The definition of labour used by HSIB includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Changes in the EN reporting requirements for Trust from	With effect from 1 April 2022, Trusts have been required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed

1 April 2022 going forward	they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB//MNSI report with the EN team within 30 days of receipt of the final report by uploading the HSIB/MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB/MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB/MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution. There is more information here: ENS Reporting Guide - July 2023 (for Member Trusts) - NHS Resolution
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases that HSIB/MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to HSIB/MNSI or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB/MNSI because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB/MNSI reference number (document the HSIB reference in the “any other comments box”). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB/MNSI maternity team (maternity@hsib.org.uk).
How should we report cases to NHS Resolution?	Trusts’ will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB/ MNSI as under investigation. They must also complete the ***EN Report*** form and attach this to the Claims Reporting Wizard: https://resolution.nhs.uk/wp-content/uploads/2023/05/EN-Report-Form.pdf
What happens once we have	Following the HSIB/MNSI investigation, and on receipt of the HSIB/MNSI report and MRI report, following triage, NHS Resolution will overlay an

reported a case to NHS Resolution?	investigation into legal liability. Where families have declined an HSIB/MNSI investigation, no EN investigation will take place, unless the family requests this.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB/MNSI as soon as they occur and to NHS Resolution as soon as HSIB/MNSI have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIBMNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and HSIB/MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

FAQs for year five of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided.** It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the Accountable officer (AO) for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution The declaration form must be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission.
Our current commissioning systems are changing, what does this mean in terms of sign off?	There have been structural changes for NHS Commissioning as a result of 2022 Health and Care Act. Where this has caused significant reconfiguration and adjustment of commissioning systems, sign off by the accountable lead for commissioning maternity services can be considered
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10,

	standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc. For more details, please refer to the conditions of the scheme.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and Accountable Office (IBC). Where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to NHS Resolution.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2023. **It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 1 February 2024, NHS Resolution will treat that as a nil response.**
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 1 February 2024**. If not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.

Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated link contacts via link on the NHS Resolution website. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme/
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results. The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal: • alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation • technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated at a later date.

Merging Trusts	Trusts that will be merging during the year four reporting period (30 May 2023 – 7 December 2023) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2022/23 and the reporting of claims and management of claims going forward.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the maternity incentive scheme?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Q2) Why have these safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Obstetric Anaesthetists Association, Royal College of Anaesthetists, HSIB, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England & Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health
- Care Quality Commission
- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff
- HSIB/CQC

Q4) How will Trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at nhsr.mis@nhs.net **by 12 noon on 1 February 2024**

Please note:

- Board declaration forms will be reviewed by NHS Resolution and discussed with the scheme's Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.
- If a completed Board declaration form is not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board in Public**	**Date: 11 January 2024**
Report Title	2023-24 Executive Summary M07	**Agenda Item Number: 13**
Lead Director	John Blakesley, Deputy CEO	
Report Author	Information Team	

Introduction	Purpose of the report: Standing Agenda Item

Key Messages to Note	**Emergency Department:**
	- There were 8,597 ED attendances in November 2023, a decrease of 125 attendances when compared to October 2023.
	- The percentage of attendances admitted, transferred or discharged within 4 hours was 75.1%, a decrease of 0.6% when compared to October 2023.
	- 83.4% of ambulance handovers took less than 30 minutes in November 2023 and 97.7% took less than 60 minutes.
	
	Outpatient Transformation:
	- There were 35,316 outpatient attendances in November 2023, a decrease of 3,400 attendances compared to October 2023.
	- 13.5% of these appointments were attended virtually and 5.5% of patients did not attend their appointment in November 2023.
	
	Elective Recovery:
	- There were 2,537 elective spells in November 2023, an increase of 275 spells from October 2023.
	- At the end of November 2023, 36,755 patients were on an open RTT pathway:
	  o 4,106 patients were waiting over 52 weeks: 44 less than in October 2023.
	  o 1,141 patients were waiting more than 65 weeks.
	- At the end of November 2023, 9,878 patients were waiting for a diagnostic test. Of these, 63.5% were waiting less than 6 weeks.
	
	Inpatients:
	- Overnight bed occupancy in adult G&A beds was 89.2% during November 2023, within the threshold of 92%. This has shown a slight increase in performance in comparison to October 2023 (88.3%).
	- A considerable proportion of beds were unavailable due to:
	  o 95 super stranded patients (length of stay 21 days or more).
	  o 86 patients not meeting the criteria to reside.
	
	Human Resources:
	- In November 2023:
	  o Substantive staff turnover was 13.0%, compared to 13.1% in October and 14.1% in September 2023.
	  o Agency expenditure decreased to 3.3% in November 2023, from 3.6% in October 2023. It remains below the threshold of 5%.
	  o Appraisals remained at 89% in November 2023, as they were in October 2023; below the 90% threshold.

	○ Mandatory Training increased to 96% in November 2023, compared to the 95% for October, September and August 2023, remaining above the 90% threshold. **Patient Safety:** - In November 2023, the following infections were reported: ○ E-Coli: 4 ○ MSSA: 2 ○ C.Diff: 2 ○ P. aeruginosa bacteraemia: 1 ○ Klebsiella Spp bacteraemia: 1		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Review** ☐

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

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

Trust Performance Summary: M08 (November 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	45.9%	92%
4.5a	RTT Patients waiting over 65 weeks	222	0
4.6	Diagnostic Waits <6 weeks	85.4%	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

November 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%	74.1%	75.1%	×	▼	×	
4.2	RTT Incomplete Pathways <18 weeks	47.4%	45.9%		35.8%	×	▼		
4.5b	RTT Patients waiting over 65 weeks	0	222		1141	×	▼		
4.6	Diagnostic Waits <6 weeks	85.6%	85.4%		63.5%	×	▲		
4.9	62 day standard (Quarterly)	85%	85%		68.0%	×	▲		

The percentage of ED attendances that were admitted, transferred, or discharged within 4 hours was 75.1%, a 0.6% decrease from October. This was above the national performance of 70.2% and above the performance of all but one other trust within our Peer Group (see Appendix 1).

The volume of open RTT pathways was 36,755, decreasing from 37,928 at the end of October 2023. Of this total, 1,141 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 Q2 2023/24, our 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 68% against a national target of 85%, increasing from 48.7% in the previous quarter. The percentage of patients to begin cancer treatment within 31 days of a decision to treat improved to 95.7% 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 75.8% against the national target of 93%. Our 28 Day Faster Diagnosis was 74% increasing from 70.2% in the previous quarter.

3.0 Urgent and Emergency Care

During November 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%	0.88%	0.62%	✓	▲	✓	
3.2	Ward Discharges by Midday	25%	25%	16.0%	18.3%	x	▼	x	
3.5	Patients not meeting Criteria to Reside	50			86	x	▼		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)	50			95	x	▲		
3.9a	Ambulance Handovers <30 mins (%)	95%	95%	78.7%	83.4%	x	▲	x	

Cancelled Operations on the Day

In November 2023, 16 operations were cancelled on the day for non-clinical reasons. Most of the cancellation reasons were related to insufficient time and equipment issues.

Patients not Meeting Criteria to Reside

The number of inpatients not meeting the criteria to reside at the end of November 2023 was 86 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 95.

Ambulance Handovers

In November 2023, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 83.4%, an increase from 78.3% in October 2023.

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%	89.3%	89.2%	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks	47.4%	45.9%		35.8%	✗	▼		
4.4	RTT Total Open Pathways	39,636	40,272		36,755	✓	▲		
4.6	Diagnostic Waits <6 weeks	85.6%	85.4%		63.5%	✗	▲		

Overnight Bed Occupancy

Overnight bed occupancy was 89.2% in November 2023, within the desired 92% threshold.

RTT Incomplete Pathways

The Trust's RTT Incomplete Pathways <18 weeks at the end of November 2023 was 35.8% and the number of patients waiting over 65 weeks was 1,141. Total RTT open pathways was 36,755.

Diagnostic Waits <6 weeks

At the end of November 2023, performance was 63.5% compared with 62.2% in October 2023.

5.0 Patient Safety

Infection Control

In November 2023, the following infections were reported:

Infection	Number of Infections
E-Coli	4
MSSA	2
C.Diff	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:

September 2023 to November 2023 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	Sep-23	Oct-23	Nov-23
Homerton Healthcare NHS Foundation Trust	79.1%	83.4%	81.7%
Milton Keynes University Hospital NHS Foundation Trust	70.0%	75.7%	75.1%
Buckinghamshire Healthcare NHS Trust	69.8%	69.6%	69.2%
Mersey and West Lancashire Teaching Hospital (Formerly Southport and Ormskirk)	69.6%	68.8%	68.4%
The Hillingdon Hospitals NHS Foundation Trust	69.9%	68.5%	64.5%
North Middlesex University Hospital NHS Trust	64.4%	66.1%	62.6%
Northampton General Hospital NHS Trust	63.1%	61.1%	62.1%
Barnsley Hospital NHS Foundation Trust	66.5%	65.7%	62.0%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	61.6%	63.0%	59.2%
Oxford University Hospitals NHS Foundation Trust	63.7%	61.7%	57.9%
Mid Cheshire Hospitals NHS Foundation Trust	60.7%	53.4%	57.9%
The Princess Alexandra Hospital NHS Trust	53.5%	49.0%	50.0%

Board Performance Report: M08 (November 2023)

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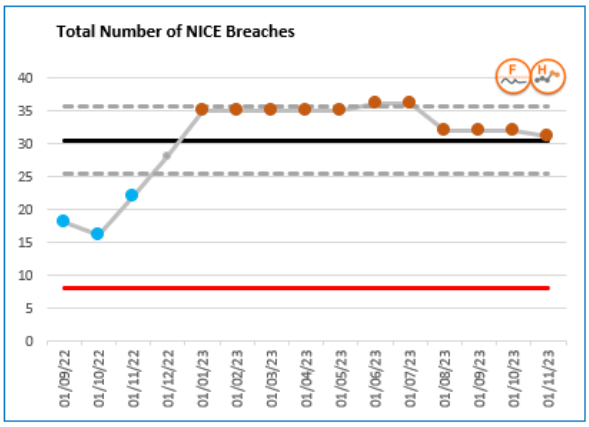
OBJECTIVE O - OTHER

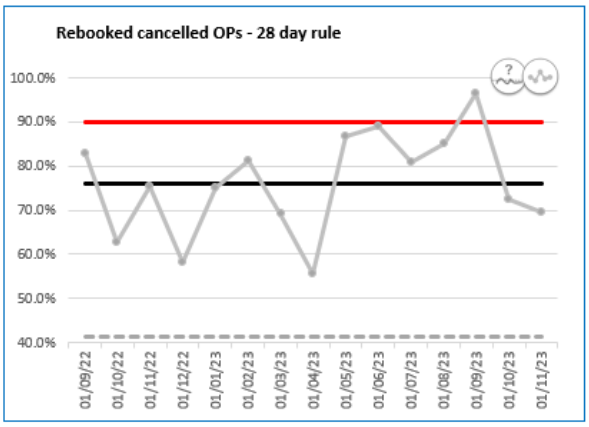
November 2023 and YTD performance against transitional targets and recovery trajectories:

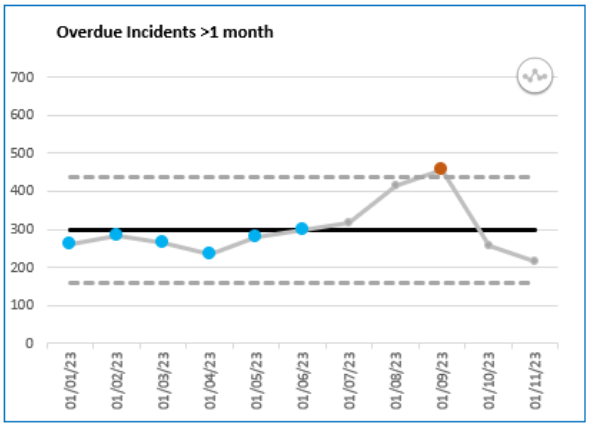
OBJECTIVES - OTHER									
ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches	8	8		31	✗	▲		
O.2	Rebooked cancelled OPs - 28 day rule	90%	90%	79.0%	69.6%	✗	▼	✗	
O.4	Overdue Incidents >1 month	TBC	TBC		217	Not Available	▲		
O.5	Serious Incidents	75	50	27	4	✓	▲	✓	

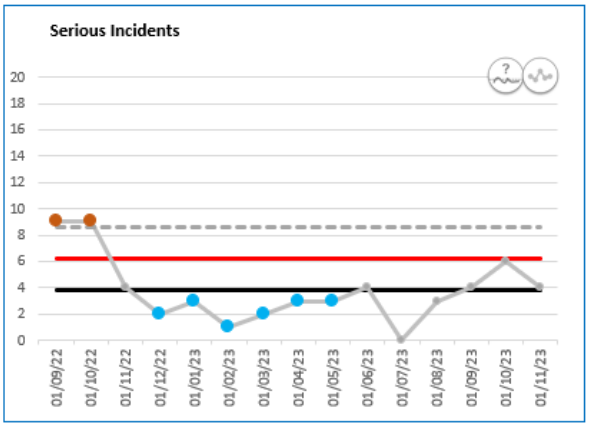
Key Points

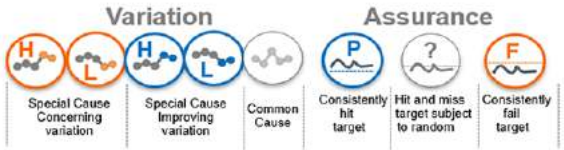
- **NICE Breaches:** The volume of NICE breaches has remained above 30 this financial year, well above the agreed threshold of eight.
- **Rebooked Cancelled Ops within 28 Days:** Of the 16 operations cancelled on the day for non-clinical reasons, 69.6% were rebooked within 28 days, below the 90% target.
- **Overdue Incidents > 1 month:** There has been an improving trend in overdue incidents in recent months, with 217 in November 2023 being the lowest reported this year.
- **Serious Incidents:** This has been trending up since July 2023 month on month, but November has seen a slight improvement compared to October 2023.
- **Serious Incidents:** There were four serious incidents reported in November 2023.











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Milton Keynes University Hospital NHS Foundation Trust

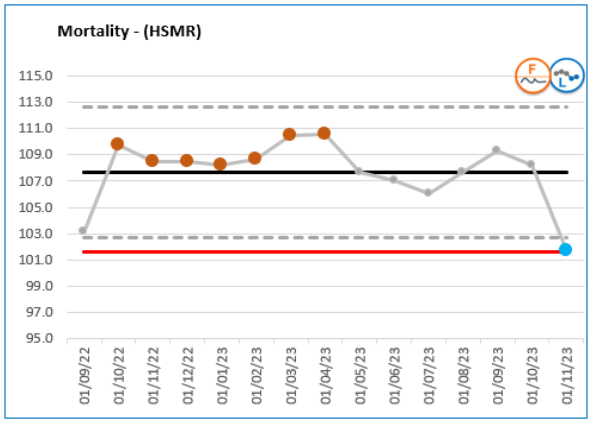
OBJECTIVE 1 – PATIENT SAFETY

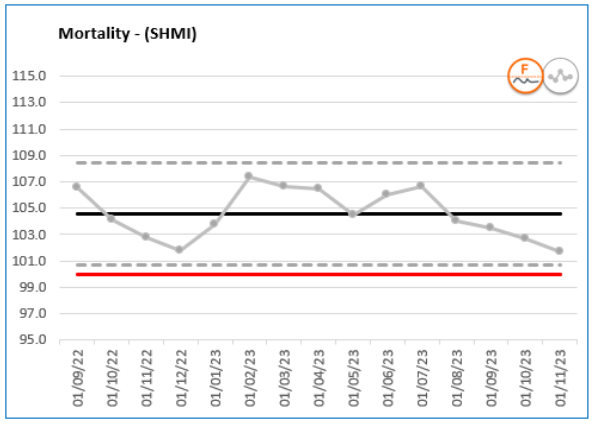
November 2023 and YTD performance against targets and thresholds:

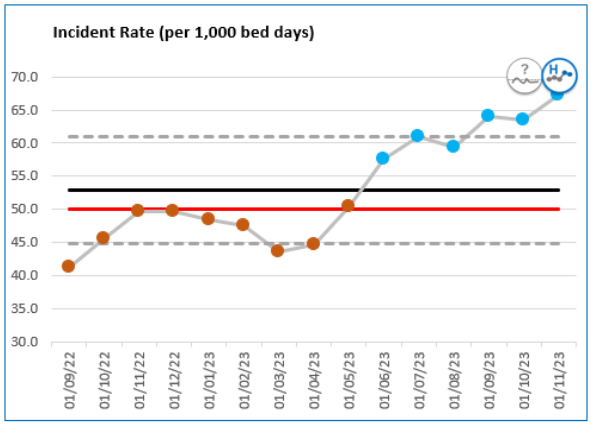
OBJECTIVE 1 - PATIENT SAFETY									
ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR) ★	97.9	97.9		101.7	✗	▲		
1.2	Mortality - (SHMI)	100.0	100.0		101.7	✗	▲		
1.6	Falls with harm (per 1,000 bed days)	0.12	0.12	0.10	0.07	✓	▲	✓	
1.8	Incident Rate (per 1,000 bed days)	50	50	58.28	67.25	✓	▲	✓	
1.13	Pressure Ulcers Classification - Total Category 2, 3, 4, DTI and Unstageable (per 1,000 bed days)	2.5	2.5	1.32	1.16	✓	▼	✓	

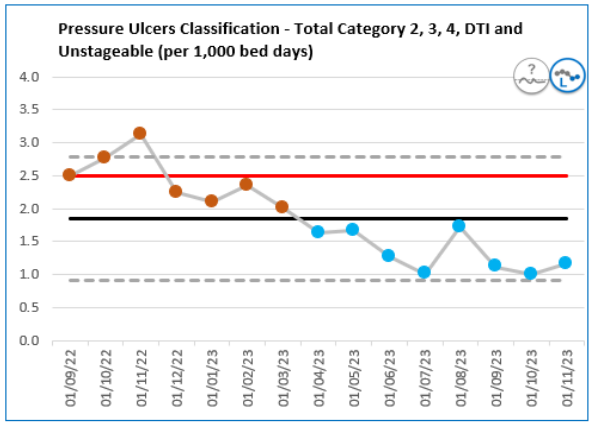
Key Points

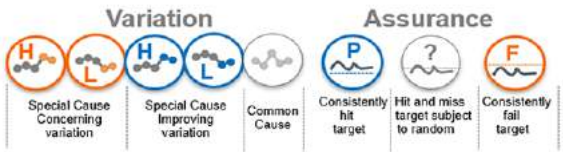
- **HSMR:** This has moved below the expected common cause variance limits, improving from 110.6 in April 2023 to 101.7 in November 2023.
- **Falls with harm:** Remained within the threshold of 0.12 with 0.07 reported falls per 1,000 bed days in November 2023.
- **Incident Rate**: The incident reporting rate continued on an upward trend and this has now consistently been above the target for six consecutive months.
- **Pressure Ulcers**: Performance has consistently improved since April 2023. There were 17 category 2, 3, 4, DTI and unstageable pressure ulcers in November 2023.











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Milton Keynes University Hospital NHS Foundation Trust

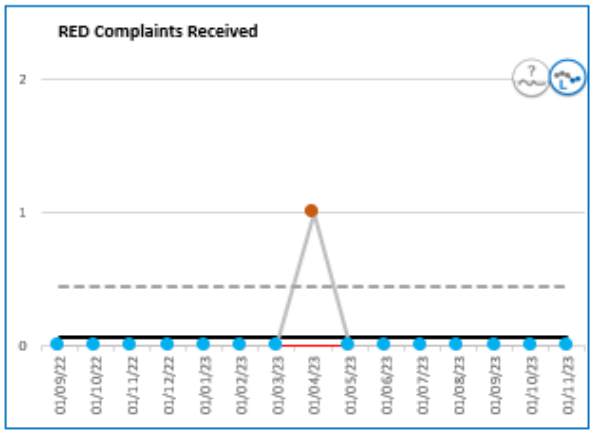
OBJECTIVE 2 – PATIENT EXPERIENCE

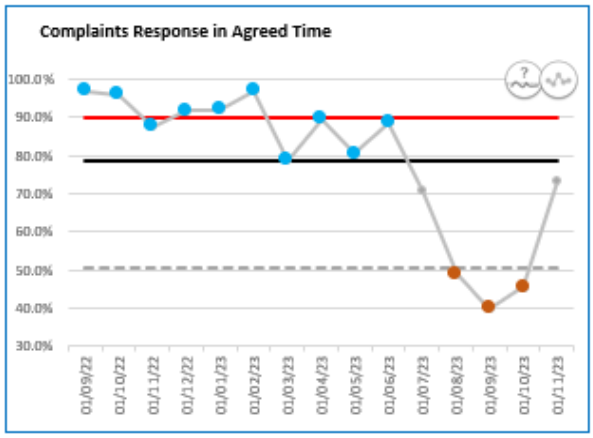
November 2023 and YTD performance against targets and thresholds:

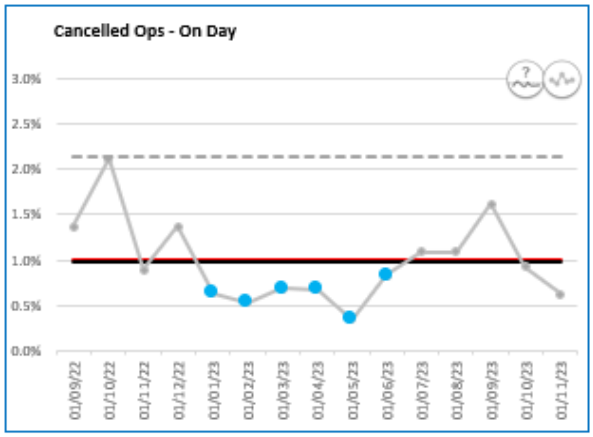
OBJECTIVE 2 - PATIENT EXPERIENCE									
ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.2	RED Complaints Received	0	0	1	0	✓	▬	✗	
2.3	Complaints response in agreed time	90%	90%	68.5%	73.4%	✗	▲	✗	
2.4	Cancelled Ops - On Day	1%	1%	0.88%	0.62%	✓	▲	✓	
2.5	Over 75s Ward Moves at Night	1,500	1,000	1,019	113	✓	▲	✗	

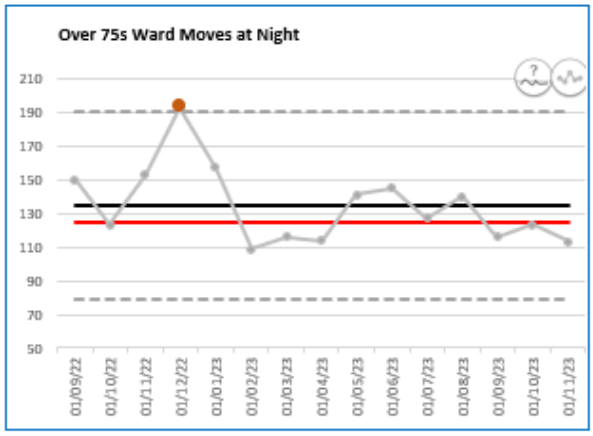
Key Points

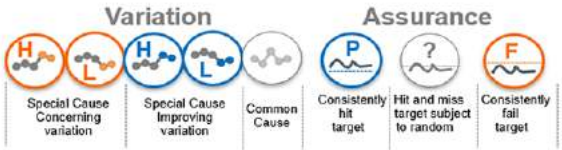
- **RED Complaints Received:** There were zero RED complaints in November and only one has been reported in the year to date (occurring in April 2023).
- **Complaints response in agreed time:** Concerning special cause variation, this has been below the lower control limit for three consecutive months, but November 2023 saw a marked improvement. Of the 64 complaints received in October 2023, 47 were responded to within the agreed time limit.
- **Operations cancelled on the Day:** 16 operations were cancelled on the day for non-clinical reasons in November 2023. Most were recorded as due to insufficient time.
- **Over 75s Ward Moves at Night**: This is showing a slight improvement from September 2023.











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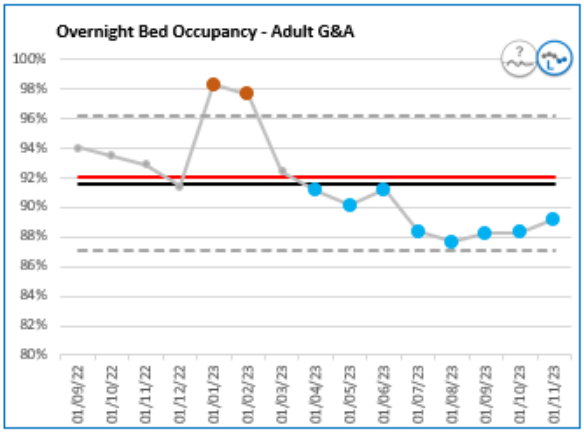
OBJECTIVE 3 – CLINICAL EFFECTIVENESS

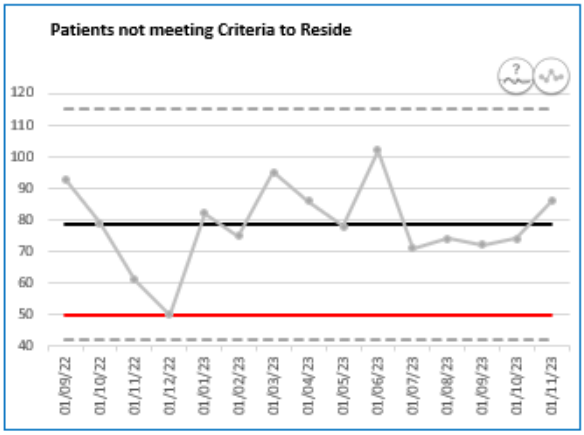
November 2023 and YTD performance against transitional targets and recovery trajectories:

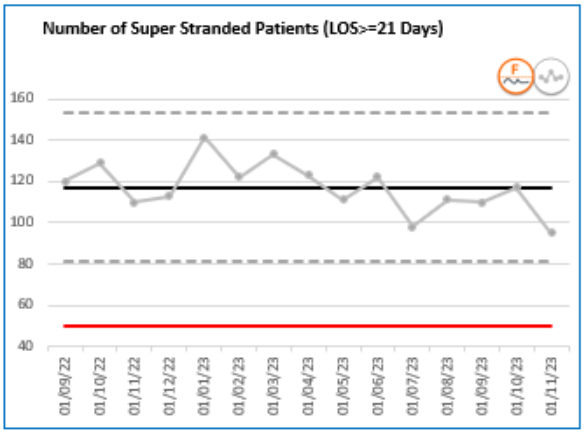
OBJECTIVE 3 - CLINICAL EFFECTIVENESS									
ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight Bed Occupancy - Adult G&A	92%	92%	89.3%	89.2%	✓	▼	✓	
3.5	Patients not meeting Criteria to Reside	50			86	×	▼		
3.6b	Number of Super Stranded Patients (LOS>=21 Days)	50			95	×	▲		
3.9a	Ambulance Handovers <30 mins (%)	95%	95%	78.7%	83.4%	×	▲	×	

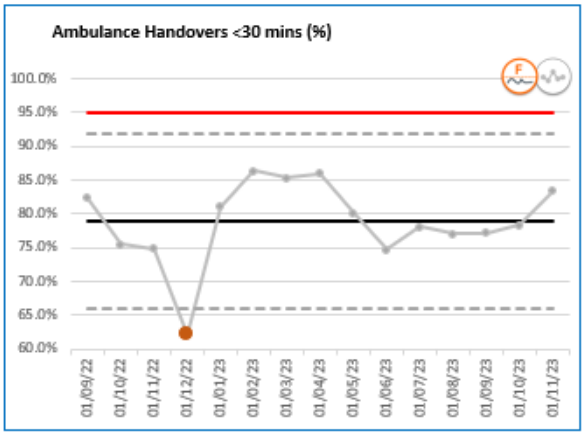
Key Points

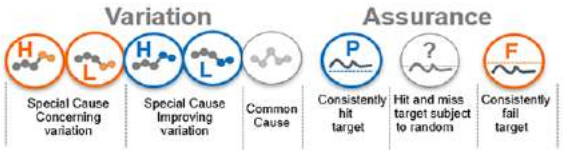
- **Overnight Bed Occupancy - Adult G&A:** Improving variation and below the mean line for eight consecutive months. Overnight occupancy was reported as 89.2% in November 2023.
- A considerable volume of hospital beds were unavailable due to:
  - 95 super stranded patients (length of stay 21 days or more).
  - 86 patients not meeting the criteria to reside.
  - 17 DTOC patients.
- **Ambulance Handovers:** This has been consistently below the 95% target but saw an upturn to 83.4% in November 2023.











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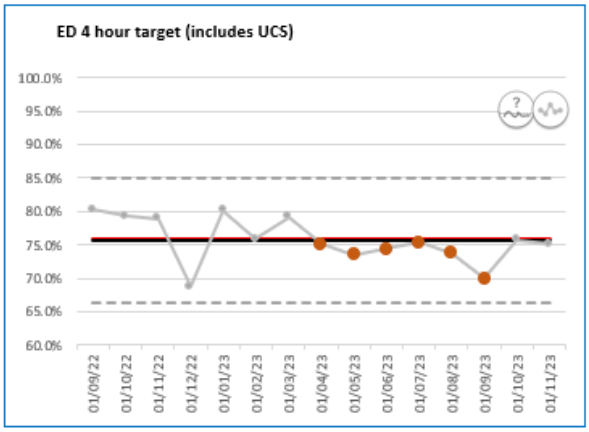
OBJECTIVE 4 - KEY TARGETS

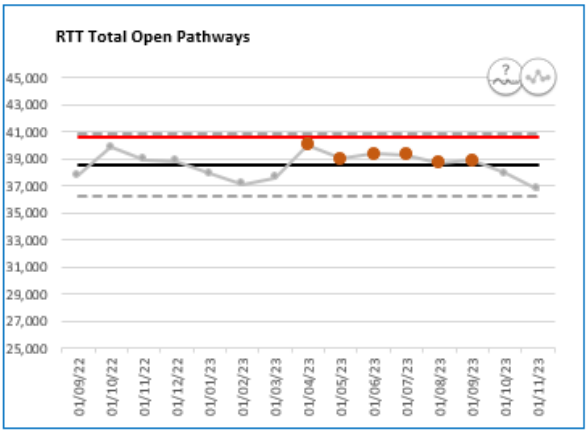
November 2023 and YTD performance against transitional targets and recovery trajectories:

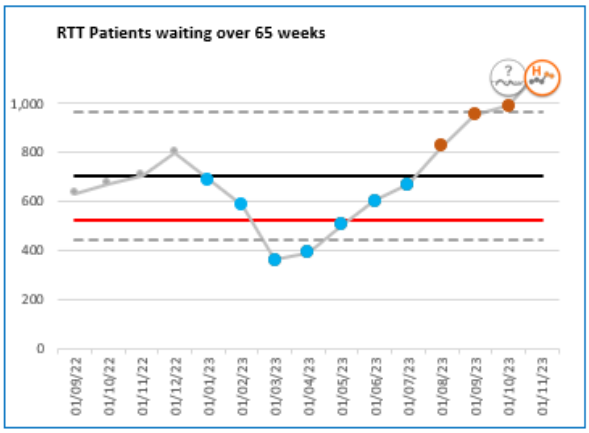
OBJECTIVE 4 - KEY TARGETS									
ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1a	ED 4 hour target (includes UCS)	76%	76%	74.1%	75.1%	✗	▼	✗	
4.4	RTT Total Open Pathways	39,636	40,272		36,755	✓	▲		
4.5b	RTT Patients waiting over 65 weeks	0	222		1141	✗	▼		
4.6	Diagnostic Waits <6 weeks	85.6%	85.4%		63.5%	✗	▲		

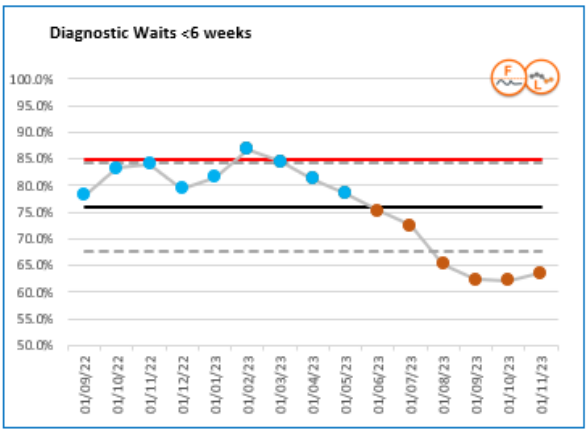
Key Points

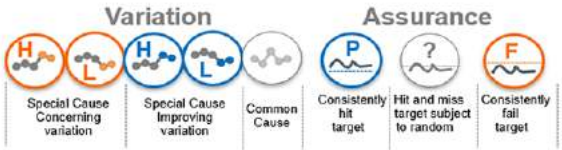
- **ED 4-hour Performance:** Performance has remained below the 76% threshold throughout this financial year and was reported at 75.1% in November 2023.
- **RTT Open Pathways:** 36,755 patients were on an open RTT pathway. Of these:
  - 4,106 patients were waiting over 52 weeks, decreasing from 4,150 in October 2023.
  - 1,141 patients were waiting over 65 weeks, increasing from 991 in October 2023.
  - 80 patients were waiting over 78 weeks.
- **Diagnostics**: 9,878 patients were waiting for a diagnostic test. Of which:
  - 63.5% were waiting less than 6 weeks.
  - Since February 2023 performance has been a downward trend but there are signs in recent months that this may be beginning to improve.











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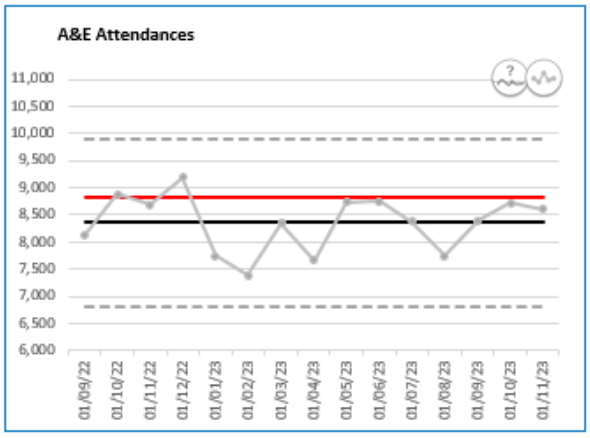
OBJECTIVE 5 - SUSTAINABILITY

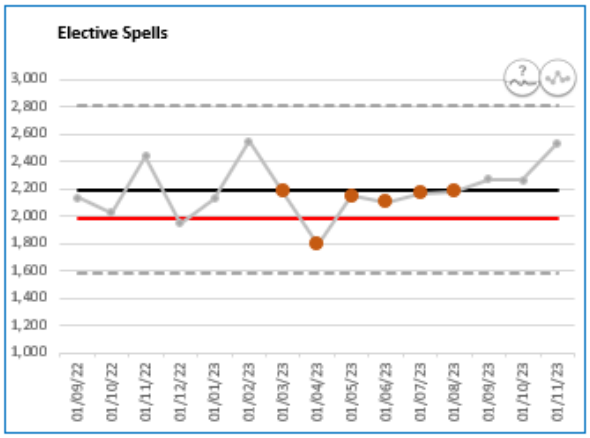
November 2023 and YTD performance against transitional targets and recovery trajectories:

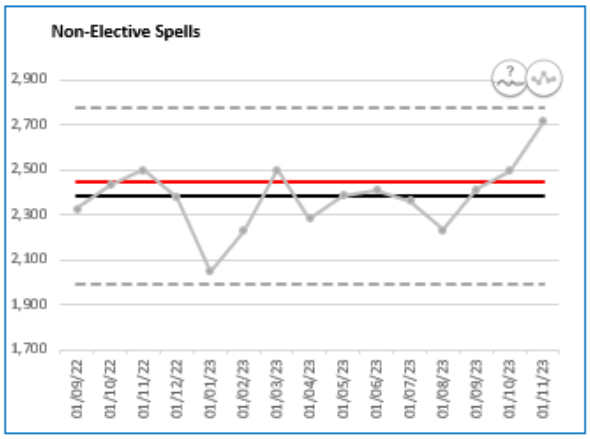
OBJECTIVE 5 - SUSTAINABILITY									
ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.2	A&E Attendances	103,507	68,715	67,004	8,597	✓	▲	✓	
5.3	Elective Spells	25,968	17,440	17,460	2,537	✓	▲	✓	
5.4	Non-Elective Spells	28,660	19,772	19,297	2,716	✗	▼	✓	
5.5	OP Attendances / Procs (Total)	409,197	273,728	288,903	35,316	✓	▼	✓	
5.6	Outpatient DNA Rate	6%	6%	5.9%	5.5%	✓	▲	✓	

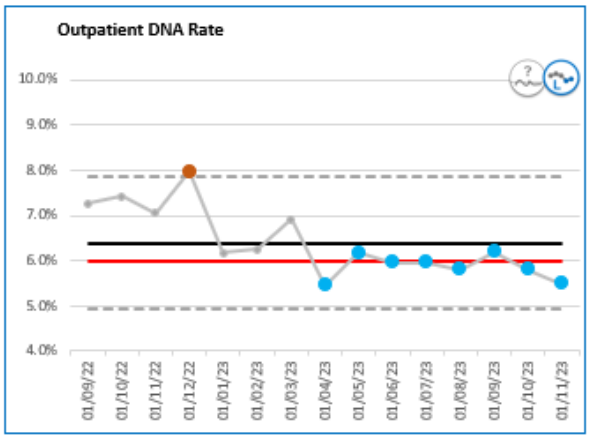
Key Points

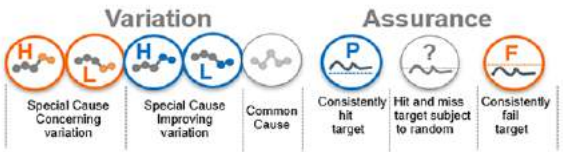
- **A&E Attendances:** There were 8,597 A&E attendances in November 2023.
- **Elective Spells:** There has been an increase in November 2023 which had 2,537 elective spells, which reflects the efforts to reduce the backlog of patients on an elective waiting list.
- **Non-Elective Spells:** Since August there has been a sharp increase in non-elective activity, there were 2,716 completed non-elective spells in November 2023, the highest volume this calendar year.
- **Outpatients:**
  - There were 35,316 outpatient attendances, a decrease from 38,716 in October.
  - 5.5% of patients did not attend their appointment, below the threshold of 6%.











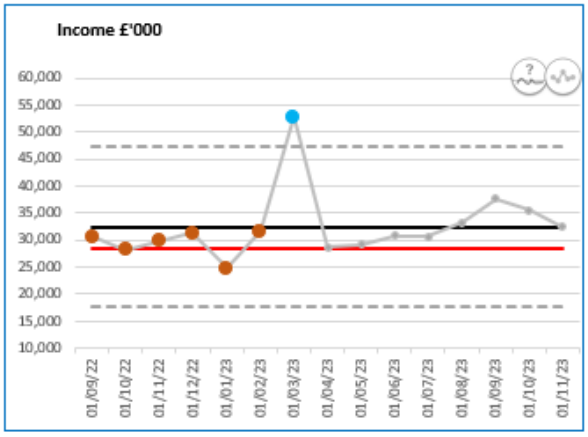
OBJECTIVE 7 - FINANCIAL PEFORMANCE

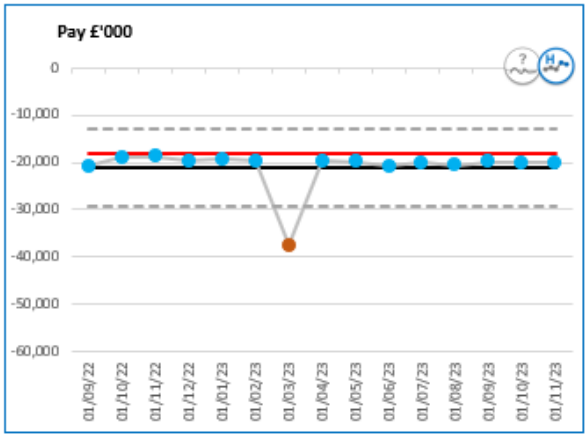
November 2023 and YTD performance against transitional targets and recovery trajectories:

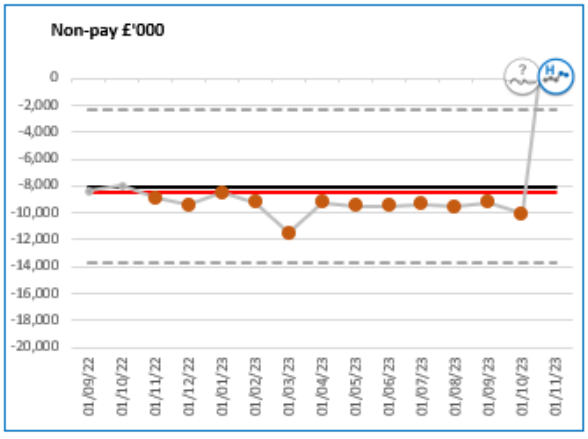
OBJECTIVE 7 - FINANCIAL PERFORMANCE									
ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000	360,945	232,828	256,247	32,440	✓	▼	✓	
7.2	Pay £'000	(215,539)	(143,831)	(161,080)	(19,961)	×	▲	×	
7.3	Non-pay £'000	(100,693)	(66,689)	(76,316)	(9,888)	×	▲	×	
7.4	Non-operating costs £'000	(44,713)	(21,736)	(21,158)	(1,913)	✓	▲	✓	

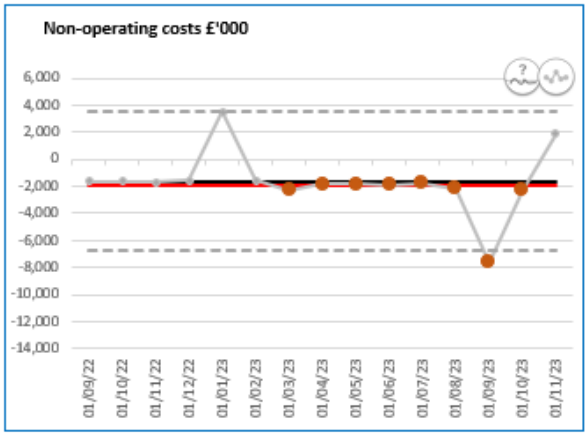
Key Points

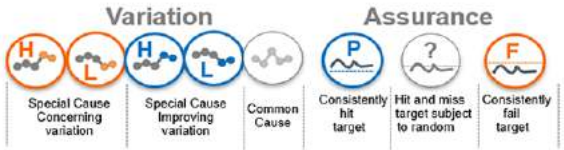
- **Income:**
- **Pay:**
- **Non-Pay:**
- **Non-Operating Costs:**











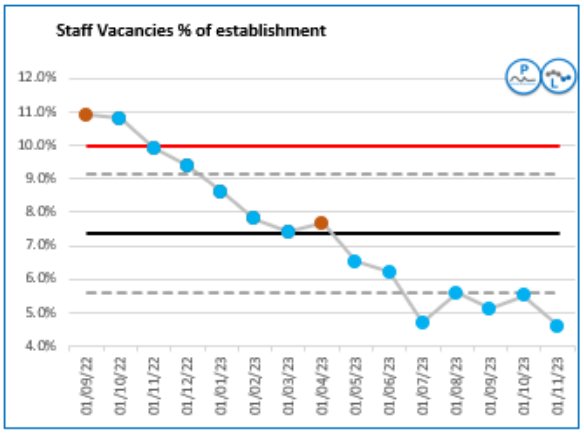
OBJECTIVE 8 - WORKFORCE PEFORMANCE

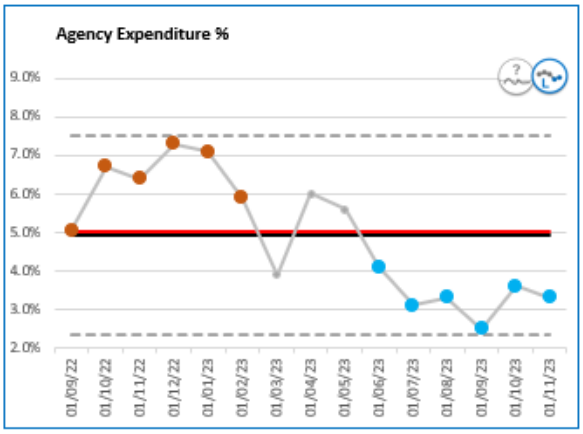
November 2023 and YTD performance against transitional targets and recovery trajectories:

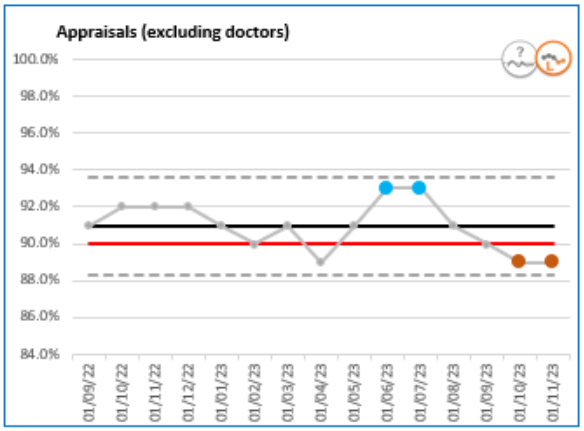
OBJECTIVE 8 - WORKFORCE PERFORMANCE									
ID	Indicator	Threshold 2023-24	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment	10.0%	10.0%		4.6%	✓	▲		
8.2	Agency Expenditure %	5.0%	5.0%	3.9%	3.3%	✓	▲	✓	
8.4a	Appraisals (excluding doctors)	90%	90%		89.0%	✗	▬		
8.5	Statutory Mandatory training	90%	90%		96.0%	✓	▲		

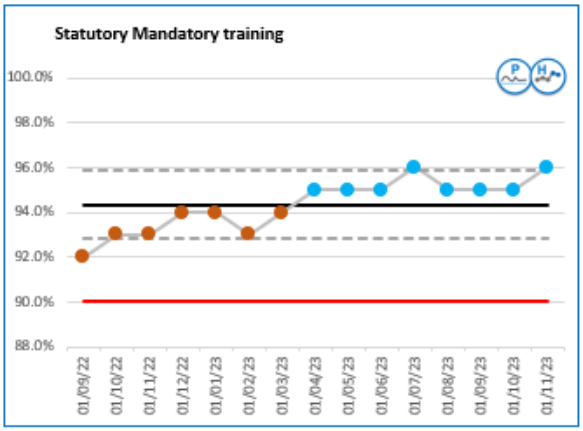
Key Points

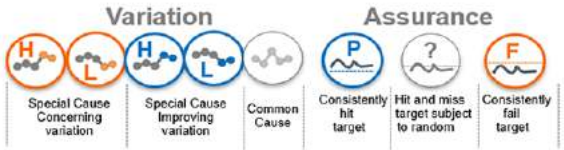
- **Staff Vacancies:** The staff vacancy rate continued to improve and remained below the lower control limit for the fifth month in a row.
- **Agency Expenditure:** This has remained below the 5% target since June 2023.
- **Appraisals:** This has shown a positive trend from April to June 2023 but has fallen below the target of 90% in October and November 2023
- **Statutory Mandatory Training:** This has remained above 95% throughout this financial year to date and has consistently outperformed the threshold of 90%.











NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting Title	**Public Board**	**Date: 11th January 2024**
Report Title	**Finance Paper Month 8 2023-24**	**Agenda Item Number: 14**
Lead Director	**Daphne Thomas**	**Interim Chief Finance Officer**
Report Authors	**Sue Fox** **Cheryl Williams**	**Interim Deputy Chief Finance Officer** **Head of Financial Control and Capital**

Introduction	This report provides an update on the financial position of the Trust at Month 8 (November 2023).		
Key Messages to Note	The Trust is reporting a £2.3m deficit (on a Control Total basis) to the end of the November 2023 which is £2.9m adverse to plan. The monthly result for November was a surplus of £0.7m. The improvement in the year to date (YTD) deficit position from last month has been driven by a recognition of elective recovery fund (ERF) over-performance as per NHS England (NHSE) guidance and this now totals £6.6m year to date. 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), £11m was reported to November representing a significant improvement on last month's total of £9.2m. 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 NOVEMBER 2023

TRUST BOARD

CONTENTS

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 (ERF) 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 (£2.9m), supernumerary costs of international recruits (£1.3m) and industrial action costs (£0.8m). Agency expenditure has reduced by 50% since April, although bank expenditure remains static. Non-pay is above plan due to drugs costs (£3.4m), clinical consumables in unfunded escalation areas (£2.8m) and clinical outsourcing (£2.5m).

(7.) Control Total Deficit - The Trust is reporting a £2.3m deficit to the end of November.

(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 – £11m efficiency delivered to date (£3.9m recurrent and £7.1m non-recurrent). Forecast of £17m made-up of risk adjusted pipeline and non-recurrent mitigation.

(11.) Cash – Cash balance is £17.0m, equivalent to 17 days cash to cover operating expenses. Note – no payment received for ERF income M1-8.

(12.) Capital – Capital expenditure is lower than plan, due to timing of business case approvals earlier in the year. There is no risk to slippage in expenditure plans at year end. The year end forecast has been revised to take account of the change in donated funding, recognising that £5m private donor funding will not be received until 2024/25 and also includes the approved IFRS16 allocation.

Measures

Ref	All Figures in £'000	Month 8 YTD Plan	Month 8 YTD Actual	Month 8 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	216,998	231,103	14,105	325,498	355,141	29,643	
2	Other Revenue	20,309	25,144	4,835	42,168	37,170	(4,998)	
3	Pay	(148,655)	(161,079)	(12,425)	(222,774)	(239,922)	(17,148)	
4	Non Pay	(66,795)	(76,316)	(9,521)	(100,853)	(115,487)	(14,634)	
5	Financing & Non-Ops	(15,995)	(15,358)	637	(24,139)	(24,139)	-	
6	Surplus/(Deficit)	5,863	3,493	(2,369)	19,900	12,763	(7,137)	
7	Control Total Surplus/(Deficit)	595	(2,306)	(2,900)	-	-	-	

Memos

8	IA Cost	-	2,974	2,974	-	5,098	5,098	
9	High Cost Drugs	(15,378)	(16,945)	(1,567)	(23,048)	(23,048)	-	
10	Financial Efficiency	11,557	11,005	(552)	17,335	17,335	-	
11	Cash	20,286	17,014	(3,272)	29,995	29,995	-	
12	Capital Plan (inc Donated)	(29,146)	(27,194)	1,952	(46,842)	(45,975)	867	

Key message

The Trust is reporting a £2.3m deficit (on a Control Total basis) to the end of the Nov 2023. This is £2.9m adverse to plan. The Trust is forecasting a breakeven year-end position, this is 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, as well as continuing income from ERF.

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 the annual efficiency target, however this is supported by non-recurrent schemes of material value.

ERF performance is currently above the new 102% target, with income showing £6.6m above the target as at M08. The Trust expects the ERF performance payments from December onwards, as confirmed by the ICB.

The capital expenditure programme is £2m 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

FINANCIAL PERFORMANCE

2. **Summary Month 8**

Financial performance on a Control Total basis is a deficit of £2.3m YTD and a surplus of £0.7m in month, against a break-even plan. Overspends on pay costs are partly offset by increased income year to date.

All Figures in £'000	Month 8 Plan	Month 8 Actual	Month 8 Var	Month 8 YTD Plan	Month 8 YTD Actual	Month 8 YTD Var	Plan Plan	Plan Forecast	Plan Var
Clinical Revenue	27,125	30,019	2,894	216,998	231,103	14,105	325,498	355,141	29,643
Other Revenue	1,774	2,423	649	14,609	18,937	4,328	21,646	23,784	2,138
Total Income	28,899	32,442	3,543	231,608	250,040	18,432	347,144	378,925	31,781
Pay	(18,562)	(19,961)	(1,399)	(148,655)	(161,079)	(12,425)	(222,774)	(239,922)	(17,148)
Non Pay	(8,428)	(9,888)	(1,460)	(66,795)	(76,316)	(9,521)	(100,853)	(115,487)	(14,634)
Total Operational Expenditure	(26,990)	(29,849)	(2,859)	(215,449)	(237,395)	(21,946)	(323,627)	(355,409)	(31,782)
EBITDA	1,910	2,593	684	16,158	12,645	(3,513)	23,517	23,516	(1)
Financing & Non-Op. Costs	(1,973)	(1,915)	57	(15,563)	(14,950)	613	(23,517)	(23,516)	1
Control Total Deficit (excl. top ups)	**(63)**	**678**	**741**	**595**	**(2,306)**	**(2,900)**	**0**	**0**	**0**
Control Total Deficit (incl. top ups)	**(63)**	**678**	**741**	**595**	**(2,306)**	**(2,900)**	**0**	**0**	**0**
Donated income	0	(2)	(2)	5,700	6,207	507	20,522	13,386	(7,136)
Depreciation	(51)	(50)	1	(408)	(407)	1	(622)	(622)	0
Impairments & Rounding	0	0	0	(24)	(1)	23	0	(1)	(1)
Reported deficit/surplus	**(114)**	**626**	**740**	**5,863**	**3,493**	**(2,369)**	**19,900**	**12,763**	**(7,137)**

3. Clinical Income
Clinical income shows a favourable variance of £14.1m YTD and £2.9m 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 £4.3m YTD and £0.6m 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 £12.4m YTD and £1.4m in month due partly to the cost of escalation/IA/delays in CIP delivery.

6. Non-Pay
Non-pay is above plan by £1.5m in month and £9.5m YTD due to increased spend on drugs and clinical consumables relating to both escalation areas and inflationary pressures.

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

Key message
The financial position on a Control Total basis is a deficit of £2.3m YTD and a surplus of £0.7m in month, the in-month position is better than plan due to income recognised for elective recovery (ERF). 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).

Deferred income of £4.2m has been released to support the current position.

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 4% to 102%, to compensate for the industrial action.

The Trust's November (M8) ERF position shows an expected £5.3m over performance compared to the target. Combined with the Advice and Guidance (A&G) diverts of £1.3m, £6.6m 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 November for months 1-8 using:

1. April (M1) to September (M6) fully coded activity ("freeze data");
2. October (M7) partially coded activity ("flex data"); and
3. November (M8) indicative activity which has a high volume of uncoded activity.

This showed estimated overall activity of 121% versus 2019/20, and a potential ERF additional payment due of £6.6m for the first eight months (average of £0.83m per month).

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. £6.6m of additional income has been included in the financial position, based on a mix of reported performance, internal estimates and ICB A&G information.

Other Activity: 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. £11m 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 M8 of £5m.

			Pipeline					Non	
Division	Target	Tracker Value	Green	Amber	Red	Total	Variance	Recurrent	Recurrent
Medicine	3,450	2,424		21	23	2,468	*(982)*	*2,448*	*20*
Surgery	2,600	1,757	-	190	184	2,131	*(469)*	*480*	*1,650*
Womens and Childrens	1,400	1,690	-	-	-	1,690	*290*	*585*	*1,105*
Core Clinical	2,500	445	128	268	176	1,017	*(1,483)*	*783*	*234*
Corporate	2,385	2,800	279	-	-	3,079	*694*	*827*	*2,252*
Trustwide	5,000	-	5,400			5,400	*400*		*5,400*
Total	**17,335**	**9,116**	**5,807**	**479**	**383**	**15,785**	***(1,550)***	***5,123***	***10,661***

11. The risk-adjusted savings presented to date totals £15.8m (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 102% has been estimated at £6.6m YTD and £13.4m FYE.

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 8. Progress has been made during November with a risk adjusted position of £15.8m (excluding 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 November is £27.2m including donated funded schemes which is £2m 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 £10.7m, an additional £5.0m 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, Digital Diagnostic funding and Endoscopy funding. The Trust has now received approval for its IFRS16 lease funding of £3.7m which is in line with the Trust requirements. The current requested CDEL is £32.6m which includes ICS allocation, leases and nationally approved funding.

14. In addition, the Trust has external funding from donations of £13.4m , which has reduced by £5m due to the timing of the donor funding that is now expected in 2024/25 rather than 2023/24 which is excluded from the CDEL allocation. The Trust's total forecast spend for 2023/24 is £46m 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			*3.66*		3.66		
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		
Endoscopy Funding			0.30		0.30		
Sub Total CDEL	**18.27**	13.27	14.33	5.00	**32.60**		**32.60**
Donated Funding							
Council (Radiotherapy & CDC)						10.70	
Donor (Radiotherapy)						0.00	
Salix						2.68	
Small donated schemes						0.03	
Total Donated Funding						**13.41**	**13.41**
Total Capital							**46.01**

Capital Item	**Value of approved BC £m** £m	**23/24 YTD Mth 8 Plan £m**	**23/24 YTD Mth 8 Actual £m**	**YTD Variance to YTD Plan £m** £m	**Status**
Pre-commitments from 22/23	**1.88**	**1.42**	**1.10**	**- 0.31**	
Scheme Allocations For 23/24 schemes (detailed below)	**12.35**	**14.80**	**14.27**	**- 0.53**	
CBIG including IT and Contingency	4.39	2.23	1.63	-0.60	
Strategic Radiotherapy	4.20	3.98	3.17	- 0.81	
Strategic Salix	1.99	1.53	-	- 1.53	
Strategic Contingency Allocated	1.27		1.23	1.23	
Hospital capacity (Build & Fees)	0.50	0.00	0.02	0.02	
Funding to be allocated	0.00	7.06	0.00	-7.06	
Adjustment			8.23	8.23	
(ICS CDEL Requested)	**14.23**	**16.22**	**15.38**	**- 0.84**	
Nationally approved schemes (detailed below)	**8.98**	**4.90**	**3.33**	**- 1.57**	
NHP	1.16	0.77	0.56	- 0.21	
Digital Diagnostic Funding -Pathology	0.36	0.10	0.04	- 0.06	
Digital Diagnostic Funding - Imaging	0.00	0.08	0.00	- 0.08	
CDC - Lloyds Court & Whitehouse Park	3.95	3.95	2.73	- 1.22	
Imaging Transformation - CT Scanner	0.90	0.00	0.00	-	
Endoscopy	0.30	0.00	0.00	-	
UEC (supporting Hospital Capacity Schemes)	2.31	0.00	0.00	-	
CDEL Submitted capital plan	**23.21**	**21.12**	**18.70**	**- 2.41**	
New Leases Impact under IFRS 16	2.36	2.32	2.32	0.00	
Submitted CDEL capital plan	**25.57**	**23.44**	**21.02**	**-2.41**	
Donated Funded Schemes (excluded from CDEL)	20.55	5.70	6.18	0.48	-
Total Capital spend	**46.12**	**29.14**	**27.20**	**-1.94**	

CASH

16. Summary of Cash Flow

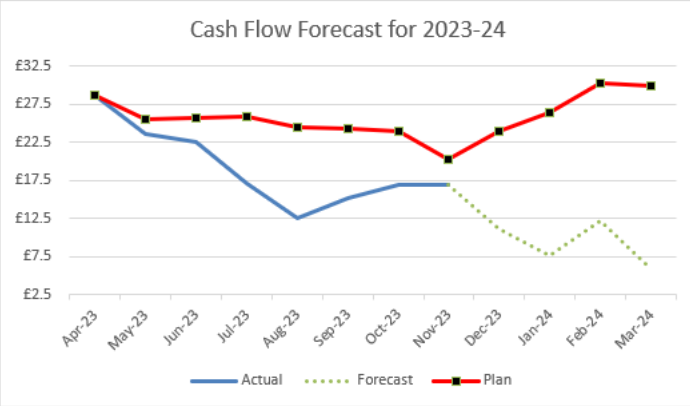
The cash balance at the end of November was £17.0m, £3.0m lower than the planned figure of £20m and a £0.0m change on last month's figure of £17.0m (see opposite).

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. Payment for ERF income for M1-5 has been agreed with BLMK ICS and will be paid in January 2024.

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 M8 YTD Number	Actual M8 YTD £'000	Actual M7 YTD Number	Actual M7 YTD £'000
Non NHS				
Total bills paid in the year	47,692	134,909	42,858	121,452
Total bills paid within target	43,970	125,580	39,312	112,681
Percentage of bills paid within target	**92.2%**	**93.1%**	**91.7%**	**92.8%**
NHS				
Total bills paid in the year	1,381	6,836	1,239	6,103
Total bills paid within target	1,069	3,345	968	2,769
Percentage of bills paid within target	**77.4%**	**48.9%**	**78.1%**	**45.4%**
Total				
Total bills paid in the year	**49,073**	**141,745**	**44,097**	**127,555**
Total bills paid within target	**45,039**	**128,925**	**40,280**	**115,450**
Percentage of bills paid within target	**91.8%**	**91.0%**	**91.3%**	**90.5%**

Key message

Cash at the end of November was behind plan at £17.0m. The Trust has fallen below the 95% target for BPPC, due to issues experienced by SBS during their repatriation of Accounts Payable (AP) services, and ongoing agency invoicing issues. Management is working to rectify payment performance to levels required.

BALANCE SHEET

19. Statement of Financial Position

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

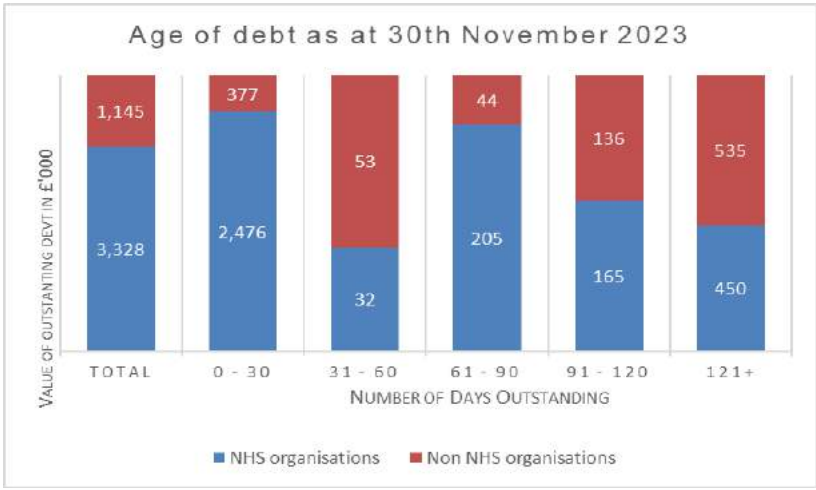
- Non-Current Assets have increased from March 23 by £15.8m; this is driven by capital purchases in year offset by in year depreciation.
- Current assets have increased by £3.2m; this is due to the decrease in cash £13.0m, offset by a £16.2m increase in receivables.
- Current liabilities have increased by £6.9m; this is due to the £6.8m increase in payables, £1.7m increase in deferred income; offset by the £1.3m decrease in current Right of Use assets and £0.3m decrease in provisions.
- Non-Current Liabilities have increased from March 23 by £2.8m; this is due to the Right of Use assets, related to IFRS 16.

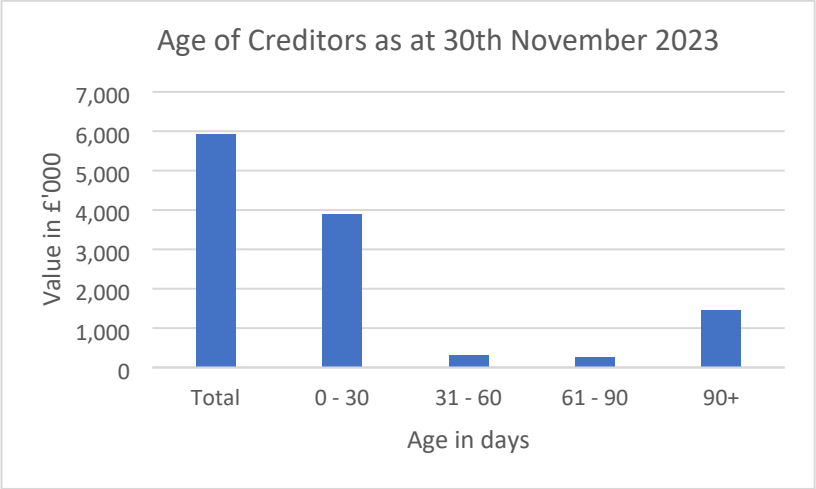
20. Aged debt

- The debtors position as of November 23 is £4.0m, which is an increase of £2.1m from the prior month. Of this total £1.0m is over 121 days old.
- The three largest NHS debtors are, Bedfordshire Hospitals NHS Foundation Trust £1.4m relating to Cancer Alliance Funding, Oxford University Hospitals NHS FT £0.8m relating to both Renal and Pharmacy recharges, NHS England £0.1m relating to salary recharges. The largest Non-NHS debtors include £0.1m for overseas patient, £0.2m with Medical Property Management £0.1m for utility recharges NHS Property Services £0.2m relating to utility recharges.

21. Creditors

- The creditors position as of November 23 is £4.3m, which is a decrease of £2.8m from the prior month. Of this, £2.3m is over 30 days with £1.3m approved for payment.





Key message

Main movements in year on the statement of financial position are the reduction in cash of £13.0m, the current assets increase of £3.2m, the non-current assets increase of £15.8m, the current liabilities increase of £6.9m and the non-current liabilities increase of £2.8m.

RECOMMENDATIONS TO BOARD

22. Trust Board is asked to note the financial position of the Trust as of 30th November and the proposed actions and risks therein.

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 30th November 2023

	FY23	M8 CUMULATIVE			M8			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M7 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatients	50,893	34,949	42,741	7,792	4,440	6,824	2,383	9,010 ▼	(2,186)
Elective admissions	31,551	21,697	22,528	831	2,928	3,658	731	3,249 ▲	409
Emergency admissions	84,791	60,401	60,402	1	6,976	6,984	8	8,143 ▼	(1,159)
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	13,296	13,296	(0)	1,722	1,722	(0)	1,943 ▼	(221)
Other Admissions	2,168	1,478	1,477	(2)	176	176	(0)	229 ▼	(53)
Maternity	20,418	13,823	13,815	(7)	1,710	1,709	(1)	2,111 ▼	(402)
Critical Care & Neonatal	6,713	4,364	4,369	5	549	549	0	823 ▼	(274)
Imaging	6,815	4,593	4,593	0	631	631	0	678 ▼	(46)
Direct access Pathology	5,792	3,849	3,849	(0)	541	541	0	543 ▼	(2)
Non Tariff Drugs and Devices (high cost/individual drugs)	21,142	13,935	13,943	8	1,868	1,870	2	1,726 ▲	143
Other (inc. home visits and best practice tariffs)	5,965	(1,958)	3,518	5,476	(239)	(467)	(228)	(5,007) ▲	4,540
CQUINS	0	0	0	0	0	0	0	0 ▲	0
Contract Risk Provision - General challenge & CIP offset	0	0	0	0	0	0	0	0 ▲	0
RTT Plans	0	0	0	0	0	0	0	0 ▲	0
Other Adj	0	0	0	0	0	0	0	0 ▲	0
National Block/Top up	69,513	46,572	46,572	0	5,822	5,822	0	6,958 ▼	(1,136)
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**	**216,998**	**231,103**	**14,105**	**27,125**	**30,019**	**2,894**	**30,405 ▼**	**(387)**
Non-Patient Income	21,646	14,609	18,937	4,328	1,774	2,423	649	2,755 ▼	(332)
Donations	20,522	5,700	6,207	507	0	(2)	(2)	350 ▼	(352)
Non-Patient Income	**42,168**	**20,309**	**25,144**	**4,835**	**1,774**	**2,421**	**647**	**3,105 ▼**	**(683)**
TOTAL INCOME	**367,665**	**237,308**	**256,247**	**18,939**	**28,899**	**32,440**	**3,541**	**33,510 ▼**	**(1,070)**
EXPENDITURE									
Pay - Substantive	(202,126)	(134,849)	(136,090)	(1,241)	(16,835)	(16,971)	(136)	(17,045) ▲	74
Pay - Bank	(11,281)	(7,433)	(13,072)	(5,639)	(981)	(1,702)	(721)	(1,657) ▼	(44)
Pay - Locum	(3,064)	(2,050)	(4,893)	(2,843)	(253)	(548)	(295)	(593) ▲	45
Pay - Agency	(5,591)	(3,843)	(6,360)	(2,517)	(435)	(668)	(233)	(732) ▲	64
Pay - Other	(821)	(547)	(665)	(118)	(68)	(72)	(4)	(92) ▲	20
Pay CIP	41	27	0	(27)	3	0	(3)	0 ▲	0
Vacancy Factor	69	41	0	(41)	7	0	(7)	0 ▲	0
Pay	**(222,774)**	**(148,655)**	**(161,079)**	**(12,425)**	**(18,562)**	**(19,961)**	**(1,399)**	**(20,119) ▲**	**158**
Non Pay	(77,805)	(51,417)	(59,371)	(7,954)	(6,521)	(7,660)	(1,139)	(7,744) ▲	84
Non Tariff Drugs (high cost/individual drugs)	(23,048)	(15,378)	(16,945)	(1,567)	(1,907)	(2,228)	(321)	(2,315) ▲	87
Non Pay	**(100,853)**	**(66,795)**	**(76,316)**	**(9,521)**	**(8,428)**	**(9,888)**	**(1,460)**	**(10,059) ▲**	**171**
TOTAL EXPENDITURE	**(323,627)**	**(215,449)**	**(237,395)**	**(21,946)**	**(26,990)**	**(29,849)**	**(2,859)**	**(30,178) ▲**	**329**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**44,038**	**21,858**	**18,852**	**(3,006)**	**1,910**	**2,591**	**682**	**3,332 ▼**	**(741)**
Interest Receivable	360	240	878	638	30	97	67	90 ▲	8
Interest Payable	(687)	(458)	(456)	2	(57)	(66)	(9)	(55) ▼	(11)
Depreciation, Impairments & Profit/Loss on Asset Disposal	(16,622)	(10,991)	(10,992)	(1)	(1,398)	(1,399)	(1)	(1,398) ▼	(1)
Donated Asset Depreciation	(622)	(408)	(407)	1	(51)	(50)	1	(52) ▲	2
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0 ▲	0
DEL Impairments	(560)	(374)	(373)	1	(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**	**9,867**	**7,501**	**(2,366)**	**386**	**1,127**	**740**	**1,870 ▼**	**(743)**
Dividends Payable	(6,007)	(4,005)	(4,008)	(3)	(501)	(501)	(0)	(501) ▲	0
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**19,900**	**5,863**	**3,493**	**(2,369)**	**(114)**	**626**	**740**	**1,369 ▼**	**(743)**

Statement of Cash Flow
As of 30th November 2023

	Mth12 2022-23 £000	Mth 8 £000	Mth 7 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit)/surplus from continuing operations	(2,225)	7,453	6,312	1,141
Operating (deficit)/surplus from continuing operations	**(2,225)**	**7,453**	**6,312**	**1,141**
Non-cash income and expense:				
Depreciation and amortisation	14,941	11,399	9,950	1,449
Impairments	1,899	0	0	0
(Increase)/Decrease in Trade and Other Receivables	(8,203)	(16,183)	(10,035)	(6,148)
(Increase)/Decrease in Inventories	(1,096)	12	9	3
Increase/(Decrease) in Trade and Other Payables	(7,239)	(7,073)	(9,808)	2,735
Increase/(Decrease) in Other Liabilities	(1,935)	1,724	870	854
Increase/(Decrease) in Provisions	420	(371)	(380)	9
NHS Charitable Funds	(181)	(6,209)	(6,209)	0
Other movements in operating cash flows	1,730	(4)	(4)	0
NET CASH (USED IN) GENERATED FROM OPERATIONS	**(1,889)**	**(9,252)**	**(9,295)**	**43**
Cash flows from investing activities				
Interest received	871	878	780	98
Addition of ROU assets	(40)	0	0	0
Purchase of intangible assets	(2,673)	(7)	88	(95)
Purchase of Property, Plant and Equipment	(25,097)	(13,613)	(10,895)	(2,718)
Net cash (used in) investing activities	**(26,939)**	**(12,742)**	**(10,027)**	**(2,715)**
Cash flows from financing activities				
Public dividend capital received	8,040	5,849	2,926	2,923
Capital element of finance lease rental payments	(2,235)	422	524	(102)
Unwinding of discount	0	(373)	(326)	(47)
Interest element of finance lease	(378)	(456)	(390)	(66)
PDC Dividend paid	(4,760)	(2,638)	(2,638)	0
Receipt of cash donations to purchase capital assets	181	6,209	6,209	0
Net cash generated from/(used in) financing activities	**848**	**9,013**	**6,305**	**2,708**
(Decrease)/increase in cash and cash equivalents	**(27,980)**	**(12,981)**	**(13,017)**	**36**
Opening Cash and Cash equivalents	**57,975**	**29,995**	**29,995**	
Closing Cash and Cash equivalents	**29,995**	**17,014**	**16,978**	**36**

Appendix 3

Statement of Financial Position as of 30th November 2023

	Mar-23 Audited	Nov-23 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	204.3	221.1	16.8	8.2%
Intangible Assets	19.6	17.9	(1.7)	(8.7%)
ROU Assets	24.4	25.1	0.7	2.9%
Other Assets	3.3	3.3	0.0	0.0%
Total Non Current Assets	**251.6**	**267.4**	**15.8**	**6.3%**
Assets Current				
Inventory	5.2	5.2	0.0	0.0%
NHS Receivables	9.8	20.7	10.9	111.2%
Other Receivables	6.0	11.3	5.3	88.3%
Cash	30.0	17.0	(13.0)	(43.3%)
Total Current Assets	**51.0**	**54.2**	**3.2**	**6.3%**
Liabilities Current				
Interest -bearing borrowings	(1.8)	(0.5)	1.3	(72.2%)
Deferred Income	(18.0)	(19.7)	(1.7)	9.4%
Provisions	(2.8)	(2.5)	0.3	(10.7%)
Trade & other Creditors (incl NHS)	(51.5)	(58.3)	(6.8)	13.2%
Total Current Liabilities	**(74.1)**	**(81.0)**	**(6.9)**	**9.3%**
Net current assets	**(23.1)**	**(26.8)**	**(3.7)**	**16.0%**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(22.7)	(25.5)	(2.8)	12.3%
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)**	**(28.3)**	**(2.8)**	**11.0%**
Total Assets Employed	**203.0**	**212.3**	**9.3**	**4.6%**
Taxpayers Equity				
Public Dividend Capital (PDC)	283.2	289.0	5.8	2.0%
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)	(134.6)	3.5	(2.5%)
Total Taxpayers Equity	**203.0**	**212.3**	**9.3**	**4.6%**

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: January 2023**
Report Title	Workforce Report – Month 8	**Agenda Item Number: 16**
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 November 2023 (Month 8) 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 November (Month 8), covering the preceding 13 months.

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

Indicator	Measure	Target	11/2022	12/2022	01/2023	02/2023	03/2023	04/2023	05/2023	06/2023	07/2023	08/2023	09/2023	10/2023	11/2023
Staff in post *(as at report date)*	Actual WTE		3507.1	3524.8	3572.5	3605.1	3618.5	3636.0	3697.4	3710.4	3776.8	3744.1	3758.3	3775.2	**3820.9**
	Headcount		4001	4018	4075	4107	4142	4165	4206	4222	4293	4261	4278	4296	**4351**
Establishment *(as per ESR)*	WTE		3892.8	3892.4	3908.4	3909.8	3907.7	3951.1	3956.4	3956.0	3963.2	3965.5	3962.0	3996.0	**4005.3**
	%, Vacancy Rate - Trust Total	**10.0%**	9.9%	9.4%	8.6%	7.8%	7.4%	8.0%	6.5%	6.2%	4.7%	5.6%	5.1%	5.5%	**4.6%**
	%, Vacancy Rate - Add Prof Scientific and Technical		32.2%	32.5%	32.7%	33.2%	33.2%	31.2%	24.4%	24.4%	25.6%	25.1%	20.6%	16.1%	**15.7%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA**s)*		11.2%	9.0%	12.2%	11.3%	7.7%	9.3%	6.4%	5.3%	0.3%	3.1%	3.4%	8.2%	**9.5%**
	%, Vacancy Rate - Administrative and Clerical		7.6%	7.5%	5.5%	5.4%	5.0%	4.3%	3.0%	3.0%	2.8%	3.1%	3.7%	3.6%	**3.1%**
	%, Vacancy Rate - Allied Health Professionals		16.7%	16.4%	13.6%	12.7%	12.0%	13.6%	16.5%	17.4%	17.1%	15.3%	16.9%	15.0%	**16.0%**
	%, Vacancy Rate - Estates and Ancillary		9.0%	9.5%	8.3%	8.3%	8.6%	11.9%	8.4%	7.2%	6.2%	7.0%	7.8%	8.0%	**4.6%**
	%, Vacancy Rate - Healthcare Scientists		0.0%	1.8%	4.0%	1.7%	1.7%	1.8%	6.3%	9.3%	6.2%	6.1%	6.0%	4.2%	**0.0%**
	%, Vacancy Rate - Medical and Dental		0.0%	0.0%	0.7%	0.8%	3.9%	2.9%	0.0%	0.0%	0.0%	1.4%	0.4%	0.0%	**0.0%**
	%, Vacancy Rate - Nursing and Midwifery Registered		12.8%	12.2%	9.3%	7.4%	7.1%	7.9%	7.7%	7.1%	7.6%	6.2%	4.3%	4.2%	**2.5%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		15.3%	15.6%	15.7%	15.7%	15.3%	15.3%	15.3%	15.1%	14.8%	14.5%	14.0%	13.7%	**13.4%**
	%, Temp Staff Usage (%, WTE)		14.4%	14.5%	14.5%	14.5%	14.5%	14.3%	14.3%	14.2%	14.0%	13.8%	13.5%	13.3%	**13.1%**
Absence (12 months)	%, 12 month Absence Rate	**5.0%**	5.3%	5.2%	5.0%	4.9%	4.8%	4.7%	4.7%	4.6%	4.5%	4.5%	4.5%	**4.5%**	*4.6%*
	- %, 12 month Absence Rate - Long Term		*2.6%*	*2.5%*	*2.5%*	*2.4%*	*2.4%*	*2.4%*	*2.4%*	*2.4%*	*2.3%*	*2.4%*	*2.3%*	***2.4%***	*2.5%*
	- %, 12 month Absence Rate - Short Term		*2.7%*	*2.7%*	*2.5%*	*2.5%*	*2.4%*	*2.3%*	*2.3%*	*2.2%*	*2.2%*	*2.2%*	*2.2%*	***2.1%***	*2.1%*
	%,In month Absence Rate - Total		4.7%	5.0%	4.1%	4.0%	4.1%	4.0%	3.9%	3.9%	4.2%	4.0%	4.1%	**5.1%**	*5.0%*
	- %, In month Absence Rate - Long Term		*2.6%*	*2.7%*	*2.4%*	*2.5%*	*2.2%*	*2.3%*	*2.3%*	*2.5%*	*2.4%*	*2.3%*	*2.3%*	***3.0%***	*3.0%*
	- %, In month Absence Rate - Short Term		*2.1%*	*2.3%*	*1.7%*	*1.5%*	*1.9%*	*1.6%*	*1.6%*	*1.4%*	*1.8%*	*1.7%*	*1.8%*	***2.1%***	*2.0%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters (In-month)		49.1	54.1	65.5	52.5	61.8	46.8	62.6	44.0	73.3	35.6	56.0	27.0	**58.9**
	Headcount, Starters (In-month)		55	60	76	55	65	53	71	52	83	42	62	30	**68**
	WTE, Leavers (In-month)		27.9	41.7	41.6	25.2	45.3	22.6	25.4	33.8	41.8	37.2	45.4	18.3	**27.3**
	Headcount, Leavers (In-month)		35	48	48	29	52	27	30	40	47	42	58	24	**30**
	%, Leaver Turnover Rate (12 months)	**12.5%**	16.9%	17.1%	17.2%	16.7%	16.4%	15.3%	14.9%	14.9%	14.4%	14.1%	14.1%	13.1%	**13.0%**
Statutory/Mandatory Training	%, Compliance	**90%**	93%	94%	94%	93%	94%	95%	95%	95%	96%	95%	95%	95%	**96%**
Appraisals	%, Compliance	**90%**	92%	92%	91%	90%	91%	89%	91%	93%	93%	91%	90%	89%	**89%**
Time to Hire (days)	General Recruitment	**35**	53	48	50	43	41	43	51	49	50	43	50	49	**46**
	Medical Recruitment (excl Deanery)	**35**	80	33	67	59	87	78	70	75	49	51	53	98	**93**
Employee relations	Number of open disciplinary cases		26	22	24	23	20	19	19	13	13	16	19	20	**21**

2.1. **Temporary staffing usage** continues to reduce, now at 13.1% with a 2% improvement in cost from the beginning of the year. 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 4351 employees in post. The **vacancy rate** is at its lowest point for over 12 months, at **4.6%** and nursing and midwifery vacancies are at **2.6%** which is the lowest it has been for over 13 months.

2.3. **Staff absence is at 4.6%** for the 12 month period and sitting at 5% in month, which is on trend for the time of year and predicted to remain around this level into M8. Managers continue to support staff back to work in line with our sickness absence and attendance policy and the Employee Relations Business Partner is undertaking a piece of work to review all long term absence cases where the employee has been out of work for a significant period of time to ensure a clear plan is in place for a supported return or outcome.

2.4. **Staff turnover** has reduced to **13%**, its lowest point for over 12 months. Retention projects in areas of high turnover continue and the HRBPs are carrying out bespoke pieces of work where turnover is high. Turnover is highest for Additional Clinical Services and Healthcare Scientists staff groups, however reductions in turnover have been achieved incrementally through the year since M1.

2.5. **Time to hire** has decreased to 46 days, despite further technical issues with the recruitment software, Trac, during the period. The manageable delays in processes are being reviewed to close the timeline where possible.

2.6. The number of **open disciplinary cases** currently sits at 21. A detailed Employee Relations case report is produced monthly to JCNC.

2.7. **Statutory and mandatory training** compliance is at 96% and **appraisals** compliance is at 89%. Corporate Services and Women's and Children's have dipped below the appraisal compliance KPI and Divisions are asked to provide assurance and action plans for recovery.

2.8. There are **16 nursing vacancies** across the Trust. Focussed recruitment to the remaining nurse vacancies is taking place.

2.9. There are **110 HCSW vacancies** (B2 and B3 and including Maternity Support Workers) across the Trust with 52 WTE going through pre-employment checks. The Recruitment Specialist Managers, together with the recruitment team, are liaising with the various departments and rolling out recruitment campaigns to attract HCSW, using some of the resources and artwork used in the BLMK attraction campaign.

3. Continuous Improvement, Transformation and Innovation

3.1. The **Trust-wide consultation** on the proposed changes to the way staff are paid during periods of annual leave closed in M9 and employees have been notified that the change will take place from 1st April and employees will notice the change from their April payslip.

3.2. **Rostering periods changed from 1st January** with staff receiving pay for enhancements worked over a slightly longer period in January. Trust sickness absence data will be more accurate, employees' pay date for shifts worked at the end of the month will be earlier,

employees will have greater understanding of when they are paid for shifts worked as it will always be in the following month.

3.3. The automation team have now launched the **Longline Bank and Agency eForm** which is a further step to reducing paper and streamlining electronic approvals for staffing cover requests. This gives the Trust greater oversight of bank and agency spend. The next project will be creating an online process for requests to advertise which will be linked to Trac and should have a positive impact on recruitment times to hire.

4. Culture and Staff Engagement

4.1. Freedom to Speak Up Champion Training was delivered by the FTSU Guardian in December to increase our numbers across the Trust. The **FTSU Team have moved** into their new office on the hospital site (the old security office) which is hoped to increase the footfall of staff meeting with the FTSU Guardians and Champions.

4.2. The **Equality, Diversity and Inclusion Team** have created a plan for the Trust's six High Impact Actions, some of which require delivery by March 2024. Setting objectives for each Board member is a key deliverable for March and each Exec and non-Exec have a network that they are the lead for.

5. Current Affairs & Hot Topics

5.1. The Trust will be signing up to the NHS **Sexual Safety at Work Charter** following support from Execs for the zero tolerance principles. A steering group will be set up, chaired by the Executive Lead, with a view to reviewing our support, training and policies through the lens of sexual safety for our workers. The Trust already has an established Domestic Violence Policy and supportive mechanisms in place, and so building on this provision and communicating behaviours expected will further embed the cultural change programme.

5.2. The HR and OD Team piloted their **'Courageous Conversations'** training for managers in M9 The training will be updated and launched as part of the MK Way foundation programme. This development training will support managers on 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. Further communication on the many ways that employees can raise a concern will be shared during Q4 alongside an updated intranet page and posts across the site,

6. Recommendations

6.1. Members are asked to note the report.

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	**Trust Board**	**Date: 11th January 2024**
Report Title	**Risk Register Report**	**Agenda Item Number: 17**
Lead Director	***Kate Jarman, Director of Corporate Affairs***	
Report Author	***Paul Ewers, Risk Manager***	

Introduction	The report provides an analysis of all risks on the Risk Register, as of 3rd January 2024.		
Key Messages to Note	Please take note of the trends and information provided in the report. **Risk Appetite:** This is defined as the amount of risk the Trust is willing to take in pursuit of its objectives. The risk appetite will depend on the category (type) of risk.		
Recommendation ***(Tick the relevant box(es))***	**For Information** ☐	**For Approval** ☐	**For Review** √

Category	Appetite	Definition
Financial	Open	Willing to consider potential delivery options and choose while also providing and acceptable level of reward and value for money
Compliance/ Regulatory	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Strategic	Seek	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
Operational	Minimal/ As low as reasonably practicable	Preference for ultrasafe delivery options that have a low degree of inherent risk and only for limited reward potential
Reputational	Open	Willing to consider potential delivery options and choose while also providing and acceptable level of reward and value for money
Hazard	Avoid	Preference to avoid delivery options that represent a risk to the safety of patients, staff, and member of the public

Note: The Risk Appetite statements are currently under review.

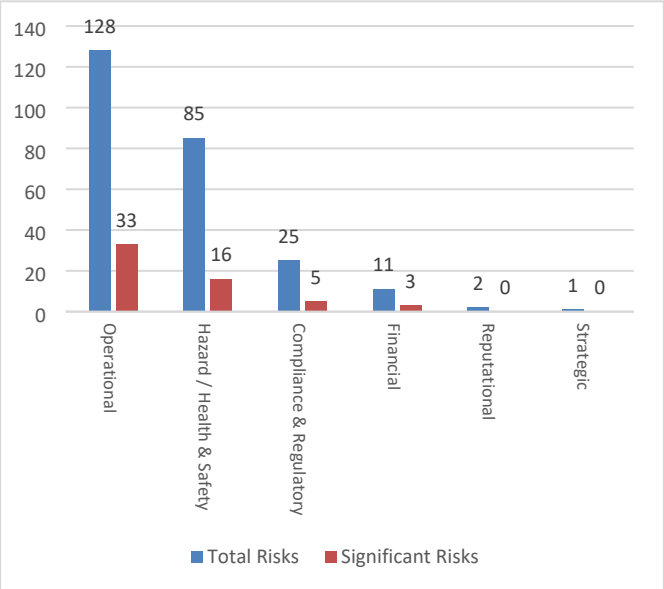
Strategic Objectives Links ***(Please delete the objectives that are not relevant to the report)***	*Objective 1: Keeping you safe in our hospital* *Objective 2: Improving your experience of care* *Objective 3: Ensuring you get the most effective treatment* *Objective 4: Giving you access to timely care*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

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

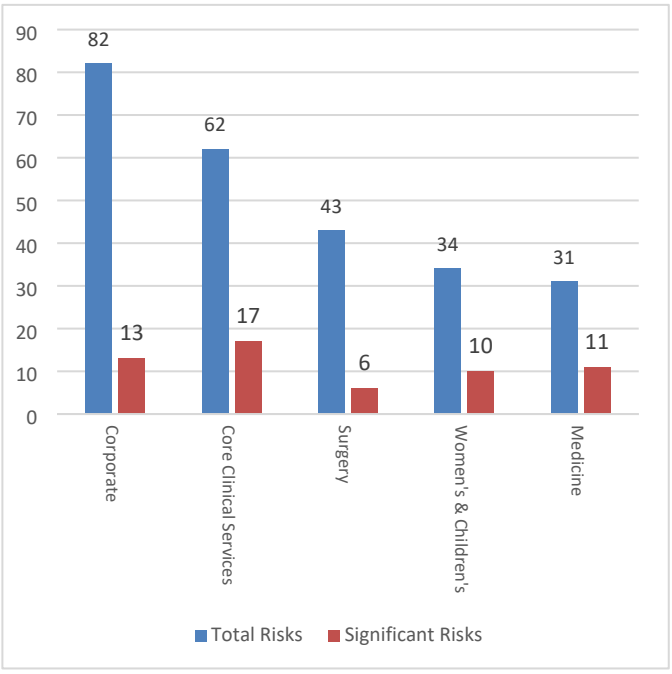


2.1 Risks by Risk Category

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 213 (85%) of the 252 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 23% of all risks recorded on the risk register.



2.2 Risks by Division

The Divisional chart shows that most risks identified relate to corporate departments (for example, Estates, Workforce etc). These departments represent 33% of the risks on the Risk Register. However, it should be noted that the Divisions represent 44 (77%) of the Significant risks.

2.3 Risk Heatmaps

Inherent Risk Score:

Likelihood \ Consequence	1	2	3	4	5
5	0	4	35	35	8
4	0	3	35	44	6
3	0	1	30	26	12
2	0	3	4	4	3
1	0	0	0	0	0

The above chart shows all 252 risks and how they are distributed in relation to their **Inherent Risk Score** (known as 'Original' score on Radar). This is the level of risk with no controls in place – in other words the level of risk the Trust would be exposed to if our controls were to fail.

This demonstrates that 140 (55%) risks were graded as significant (red) risks before any controls were put in place. 105 (42%) were graded as moderate (amber) risk and 8 (3%) risks were graded as low/very low (green) risk.

Current Risk Score:

Likelihood \ Consequence	1	2	3	4	5
5	0	6	16	13	0
4	1	7	35	21	4
3	0	14	48	23	3
2	1	10	19	15	6
1	0	1	1	8	4

The above chart shows all 252 risks and how they are distributed in relation to their **Current Risk Score**.

This demonstrates that 57 (23%) risks are currently graded as significant (red) risks, 134 (53%) are currently graded as moderate (amber) risk and 59 (23%) risks are currently graded as low/very low (green) risk.

Comparing the Inherent Risk Score and Current Risk Score heatmaps, they show the impact the Risk Owners feel the controls are having on the risks. For example, before controls 140 significant risks were identified whereas, when taking the existing controls into account, this has reduced to 57.

Target Risk Score:

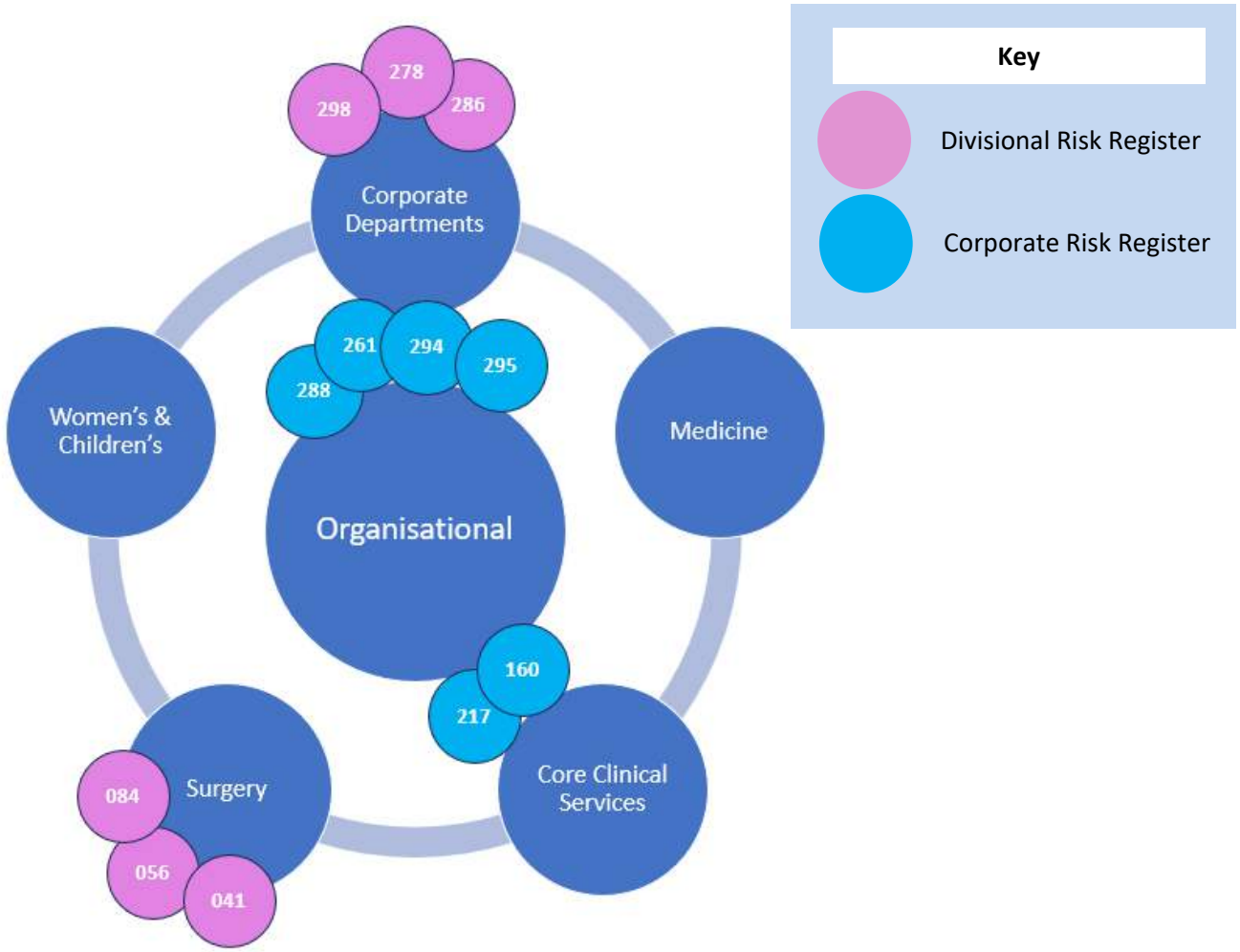
Likelihood \ Consequence	1	2	3	4	5
5	0	0	0	0	0
4	1	2	6	0	0
3	7	36	20	4	0
2	7	28	44	20	6
1	3	2	21	36	10

The above chart shows all 259 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 195 risks (77%) have a low/very low Target Risk Score.

2.3 High Consequence / Low Likelihood Risks

There are 12 risks (a decrease of 1 from the last report) 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 should they happen. The below graphic demonstrates how these risks are distributed across the Divisions and which risk are on the Corporate Risk Register.

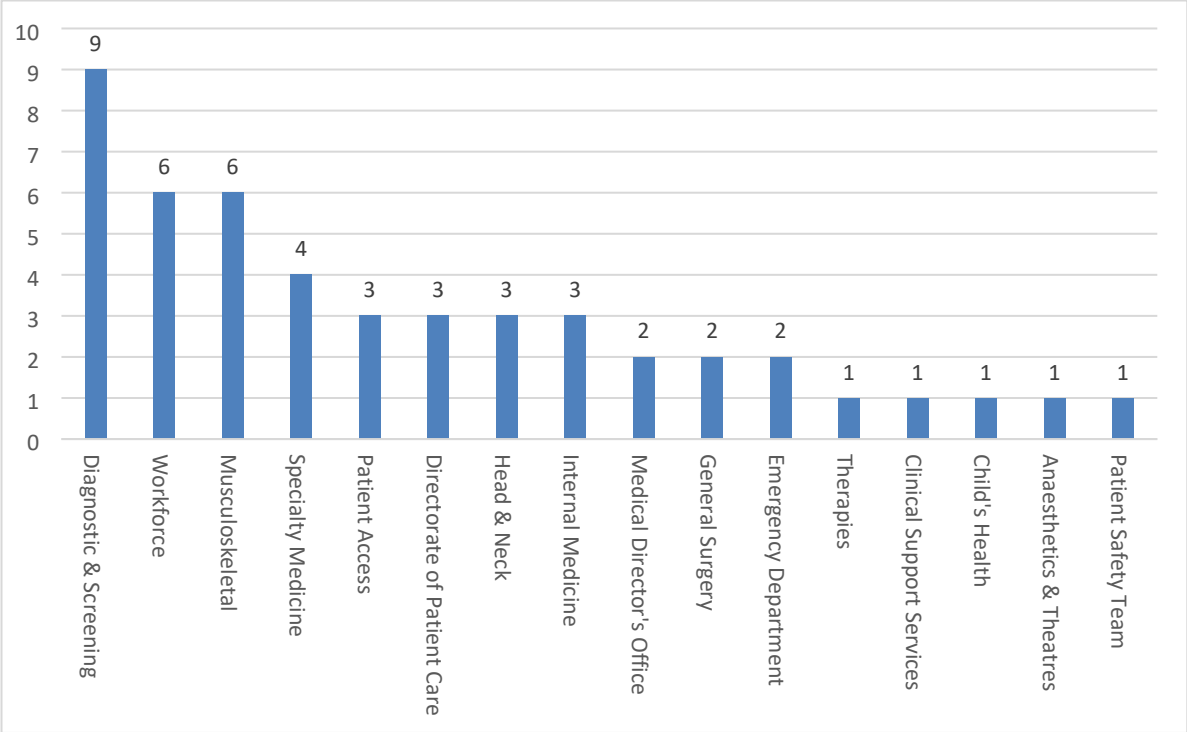


Divisional / Corporate Department Risks	Corporate Risk Register Risks
RSK-056 Single oxygen supply in Intensive Care Unit	**RSK-160** Bag Valve Masks similar to Lung Volume Recruitment bags
RSK-084 Breast Clinic capacity	**RSK-217** Nasogastric feeding
RSK-278 Accurate of Asbestos Register and database	**RSK-261** Inadequate PAT Testing
RSK-286 Inappropriate disposal of sharps	**RSK-288** Medical oxygen supply
RSK-298 Estates Continuity plan may not align Trust plan	**RSK-294** Personal injury to staff
RSK-041 Lack of knowledge/skills in specialised equipment	**RSK-295** Ladder safety / Injury

3. OVERDUE RISKS

At the time of reporting, there were 48 risks out of 252 risks (19%) overdue their review date. This represents an **increase of 37**.

3.1 Total Overdue Risks by CSU/Corporate Department



3.2 Risks Overdue Review > 1 month = 9. This is an **increase of 4** since the last report.

4. NEW RISKS = 2

Radar Reference	Lead Department / CSU /Division	Risk Owner
RSK-506	Haematology & Oncology	Sally Burnie

Please refer to the appendix for more information on each risk.

5. CLOSED RISKS = 0

Radar Reference	Risk Owner	Closure Reason

Please refer to the appendix for more information on each risk.

6. CHANGING RISKS

Risks that have increased: 6

RSK-016	Lack of flow within the organisation	Current Risk increase from 15 to 20
RSK-438	<17 year olds waiting for mental health bed in ED	Current Risk increase from 15 to 20
RSK-051	Karl Storz hardware upgrade / Incompatibility	Current Risk increase from 9 to 12
RSK-166	Increasing workflow / Lack of Consultant Pathologists	Current Risk increase from 12 to15
RSK-058	Resources for Glaucoma Follow-up Service	Current Risk increase from 8 to 9
RSK-110	Lack of dedicated triage area for maternity	Current Risk increase from 9 to 20

Risks that have decreased: 10

RSK-211	Colonisation with pseudomonas aeruginosa	Current Risk reduced from 8 to 6
RSK-041	Lack of skills with Theatres with specialised equipment	Current Risk reduced from 10 to 5
RSK-017	Significant nurse staffing vacancies in ED	Current Risk reduced from 15 to 12
RSK-402	Lack Orthopaedic Therapy staff to provide rehabilitation	Current Risk reduced from 8 to 4
RSK-440	Repeated closure of dedicated PDSU for escalation	Current Risk reduced from 9 to 3
RSK-487	Blood pressure machines not designed for pregnant pts	Current Risk reduced from 20 to 12
RSK-057	Lack of space in the Eye Clinic	Current Risk reduced from 12 to 6
RSK-495	Changing facilities for hydrotherapy / access to the pool	Current Risk reduced from 16 to 9
RSK-496	Changing facilities for hydrotherapy / access to the pool	Current Risk reduced from 16 to 8
RSK-067	vacancy gaps for experienced schedulers	Current Risk reduced from 12 to 6

7. RISK MANAGEMENT TRAINING

From March 2023 there has been a programme of monthly 'Risk Management Simply' training sessions scheduled. The session is mainly aimed at managers and Risk Owners; however, it is suitable and available to any staffing member wishing to attend the course. The Risk Management Simply training session is also part of the MK Manager's Way training programme led by the Workforce team.

Number of staff trained this month: 8

Total number of staff trained: 170

8. RISKS FOR ESCALATION TO CORPORATE RISK REGISTER

None

9. RECOMMENDATION

The Committee is asked to review and discuss this paper.

Key recommendations/decisions for Committee:

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.

10. 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	Created on	Description		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-016	22-Sep-2021	IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients	LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment, nursing patients outside of cubicles in corridors and the middle of majors,and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care	Organisation	Kirsty McKenzie-Martin	04-Dec-2023	08-Jan-2024	Pending	25	20	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-134	04-Nov-2021	If there is insufficient funding, then the Trust may be unable to meet financial plans and targets or deliver its strategic aims,	Leading to service failure and regulatory intervention THEN the Trust will be unable to meet its financial performance obligations or achieve financial sustainability	Organisation	Karan Hotchkin	12-Dec-2023	12-Jan-2024	Planned	20	20	8	Medium Term financial modelling commenced with ICS partners. (20-Nov-2023), Work with ICS partners and NHSE to mitigate financial risk.	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), Escalation of key issues to NHSE regional team for support(04-Sep-2023)	High	Treat	Risk transferred from Datix	01-Apr-2022
RSK-202	23-Nov-2021	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-Dec-2023	12-Jan-2024	Planned	20	20	8	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 £9.2m as the end of Oct 223 have been identified against the £17m target. Whilst this shortfall can be mitigated this year, the risk is around the underlying financial position. (20-Nov-2023)	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)	Medium	Treat	Risk transferred from Datix	01-Apr-2022
RSK-305	06-Dec-2021	If there is insufficient strategic capital funding available THEN the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	LEADING To financial loss and reputational damage	Organisation	Karan Hotchkin	12-Dec-2023	12-Jan-2024	Planned	16	20	10	Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24. (20-Nov-2023)	The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021), 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

Reference	Created on	Description		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-472	04-Aug-2023	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	11-Dec-2023	29-Feb-2024	Planned	25	20	10	Wider roll out of bodycam provision (11-Dec-2023), Widen environmental study to consider patients with mental health, learning disability, dementia etc – holistic approach to care, environment, distraction therapies (18-Dec-2023), 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 (18-Dec-2023), Training for staff in managing patients with mental health, learning disability, dementia etc De -escalation procedure/techniques (18-Dec-2023), Development of an information pocket card for staff (27-Oct-2023), Listening events on the road, staff engagement sessions (11-Dec-2023), Ensure feedback from incidents to staff and lessons learnt shared amongst wider organisation (18-Dec-2023), Documented strategy Review policy, local risk assessments, warning system	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	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
RSK-001	06-Sep-2021	IF all known incidents, accidents and near misses are not reported on the Trust's incident reporting system (Radar); THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher, potential under reporting to the Learning from Patient Safety Events (LfPSE) system, and potential failure to meet Trust Key Performance	Organisation	Tina Worth	27-Dec-2023	31-Mar-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	Overall incident reporting rate has shown to be increasing. referenced in governance meetings that certain types of incidents remain lowly reported though.	06-Sep-2021
RSK-035	28-Sep-2021	IF there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting. Loss of staff to primary care which offers more attractive working hours. THEN there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	LEADING TO: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines 6. harm to the patients 7. adverse impact on mental health of Pharmacy staff All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Organisation	Helen Chadwick	01-Dec-2023	31-Jan-2024	Planned	20	16	6	Actively recruiting staff (01-Dec-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	ongoing	07-Aug-2019
RSK-036	28-Sep-2021	If there is no capacity in the Pharmacy Team THEN there is a risk that Pharmacy and Medicines Policies and Procedures may not be reviewed and updated in a timely manner, nor new policies developed	Leading to: Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures Failure to meet CQC requirements Lack of guidance for staff Potential harm to patients	Organisation	Helen Chadwick	01-Dec-2023	29-Feb-2024	Planned	16	16	6	Recruitment of staff (01-Dec-2023)	Use of remote bank staff to update policies(28-Sep-2021), Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	governance gap analysis in process	01-Oct-2021

Reference	Created on	Description		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-126	04-Nov-2021	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations) THEN there will be overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Organisation	Lazarus Anguvaa	03-Nov-2023	30-Nov-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	04-Nov-2021	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs. This means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development THEN staff may be unable to cover a service that has not been serviced correctly, and the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	LEADING TO patient care and patient safety may be at risk, vulnerable children may become nutritionally compromised, the service may be unable to assess and advise new patients and review existing patients in a timely manner, and there may be an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	Organisation	Elizabeth Pryke	05-Dec-2023	05-Jan-2024	Pending	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	Insufficient time to take this forward	01-Nov-2021
RSK-158	12-Nov-2021	IF the escalation beds are open across the medical and surgical divisions. Then the additional patients that will need to be seen will put additional demand on the Inpatient Therapy & Dietetic Services that are already stretched due to long term vacancies.	LEADING TO: Patients deconditioning, nutritional needs of patients may not be met 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	22-Dec-2023	22-Jan-2024	Planned	16	15	6	agency physiotherapist and occupational therapist to cover additional workload. (13-Dec-2023), inpatient improvement project- aiming to review patient pathways to optimise staffing (01-Dec-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)	Low	Treat	Escalation bed numbers remain >60 with one occasion of ward 2b re-opening, locum requests submitted for cover of ward 2b as have been notified that ward 2b is likely to be a surge ward in January.	27-Nov-2018
RSK-159	12-Nov-2021	Patients referred to the Occupational Therapy and Physiotherapy inpatient services covering medical and surgical wards are not being seen in a timely manner due to the number of long term vacancies and national challenges to recruit to vacant posts. THEN there will be a delay in these patients being assessed, treated and discharged.	LEADING TO deconditioning of vulnerable/complex patients requiring a short period of therapy; increased length of stay; potential readmission, increased demand for packages of care requiring double handed provision. patient experience and long term quality of life will also be impacted as patients are being discharged as more dependent on care.	Organisation	Adam Baddeley	19-Dec-2023	31-Jan-2024	Planned	20	15	3	inpatient improvement programme- to ensure optimal staffing and allocation (01-Dec-2023)	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	Sickness levels have increased, delays in bank and agency approval affecting ability to cover gaps, vacancies remain above 10 WTE.	04-Mar-2019

Reference	Created on	Description		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-250	26-Nov-2021	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	LEADING TO increased clinical risk, increased risk to performance of eCARE, potential disruption to staff, and delays in the deliver or projects and realising their benefits	Organisation	Craig York	29-Nov-2023	01-Mar-2024	Planned	15	15	3	Identification of staff time and resources (11-Apr-2023), Business case being written by the end of spring 2023 to identify the amount of staff time required. Update Aug 2023 - being reconsidered during early stages of DQ review., Review volumes against historical figures to reflect reality of challenge. Include in business case. Consider additional posts for all.	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly(26-Nov-2021)	Low	Treat	Volume of work is increasing month on month without additional staff to support.	25-Jan-2023
RSK-406	09-Dec-2022	IF there is a global shortage of electronic components THEN this can impact the lead times for delivery of medical equipment	LEADING TO to inability to replace/repair aged equipment used to monitor and support patients during their hospital care.	Organisation	Ayca Ahmed	18-Dec-2023	18-Jan-2024	Planned	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	20-Jan-2023	Ongoing shortages of medicines with minimal notice or little warning	Possibility of cancellation of patient appointments/operations or a delay to treatment/discharge. Increased cost to the trust in sourcing medicines off of contract prices, courier charges, staff time	Organisation	Nicholas Beason	01-Dec-2023	31-Jan-2024	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	significant shortages continue	27-Nov-2022
RSK-002	06-Sep-2021	IF recommendations and actions from audit are not evidenced, monitored and completed in the Trust; THEN required changes to practice may not implemented and we may not be meeting best practice criteria;	LEADING TO potential impact on the top 3 Trust objectives (patient Safety, Clinical Effectiveness, Patient Experience), potential poor quality of service and associated impact on resources and potential CQC concerns re audit activity and learning from national audits	Organisation	Jacqueline Stretton	06-Dec-2023	29-Feb-2024	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	Radar Audit module in development to monitor audit recommendations and improvement actions	06-Sep-2021
RSK-003	06-Sep-2021	IF existing Radar governance system does not support meeting Trust/legal/stakeholder requirements and are unsupported by the Trust IT department or an external IT provider; THEN the Trust is unable to meet statutory and mandatory Good Governance requirements and accreditations;	LEADING TO potential delays in care, inappropriate/incorrect/sub-optimal treatment; potential increase in incidents, complaints and claims; reduced CQC rating and potential enforcement actions	Organisation	Tina Worth	27-Dec-2023	31-Mar-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	Risk Manager working collaboratively with radar to get radar function to best meet organisational needs	06-Sep-2021

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RSK-093	22-Oct-2021	IF there is insufficient staffing within the dietetics department in paediatrics THEN they will be unable to assess and advise new outpatients and review existing outpatients in a timely manner.	LEADING TO an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority	Organisation	Elizabeth Pryke	19-Dec-2023	19-Jan-2024	Planned	16	12	6	review of patient pathways to reduce need for outpatient appointments (05-Dec-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	New patient pathway for selective eaters introduced 1.1.24, to ensure patients with most clinical need are seen. To monitor waiting lists.	01-Oct-2021
RSK-206	23-Nov-2021	IF the Trust is unable to recruit staff of the appropriate skills and experience; there continues to be unplanned escalation facilities; There are higher than expected levels of enhanced observation nursing; and there is poor planning for peak periods / inadequate rostering for annual/other leave. THEN the Trust may be unable to keep to affordable levels of agency and locum staffing	LEADING TO Adverse financial effect of using more expensive agency staff and potential quality impact of using temporary staff	Organisation	Karan Hotchkin	12-Dec-2023	12-Jan-2024	Planned	16	12	9	Weekly Agency review by Executive Directors (20-Nov-2023)	Weekly vacancy control panel review agency requests(23-Nov-2021), Control of staffing costs identified as a key transformation work stream(23-Nov-2021), Capacity planning(23-Nov-2021), Robust rostering and leave planning(23-Nov-2021), Escalation policy in place to sign-off breach of agency rates(23-Nov-2021), Fort-nightly executive led agency reduction group meeting with aim of delivering reduction in both quantity and cost of agency used(23-Nov-2021), Agency cap breaches are reported to Divisions and the FIC(23-Nov-2021), Divisional understanding of how to reduce spend on temporary staffing to be developed(23-Nov-2021)	Medium	Treat	Additional controls are in place for long lines of agency that require an Exec sign off	01-Apr-2022
RSK-219	25-Nov-2021	IF metal butterfly needles are used for administering subcutaneous infusions via syringe drivers, and bolus subcutaneous injections, particularly in palliative and end-of-life care THEN there is a risk that the member of staff (hospital or community) may sustain a needle stick injury as they are withdrawing the needle when the infusion is stopped	LEADING TO the staff being at risk of coming into contact with contaminated blood	Organisation	Yvonne Christley	02-Jun-2023	31-Jul-2023	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	25-Nov-2021	IF the Research Nurses have a clinic room without a couch or trolley THEN they will be unable to perform their procedures and examinations	LEADING TO safety risk to patients, decrease patients recruitment	Organisation	Antoanela Colda	24-Jul-2023	21-Dec-2023	Overdue	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-229	25-Nov-2021	IF there is poor quality of data input into the eCare system THEN there could be consequential impact on the data flow into the Trust data warehouse and reporting for both performance management and contracting (commissioners) data	LEADING TO Impacts all performance reporting. Impacts “Contracts” reporting leading to a loss of income for the Trust	Organisation	Ian Fabbro	29-Nov-2023	01-Mar-2024	Planned	12	12	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	Treat	Risk increased due to influx of issues coming to IT linked to poor use of eCARE and generation of poor veracity of data.	25-Jan-2023

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RSK-230	25-Nov-2021	IF a major incident was to occur requiring the trust to respond above service levels THEN there could be an impact to normal service. Eg/elective and inpatient care.	LEADING TO changes in routine working processes and procedures across the Trust for the duration of the major incident response and recovery phases.	Organisation	Adam Biggs	18-Dec-2023	18-Mar-2024	Planned	16	12	12	Development and delivery of EPRR Work Programme 2024 - to be signed off by Emergency Planning Steering Committee in February 2024.	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	Tolerate	Risk will be revised following sign-off on the MKUH EPRR annual work plan 2024	25-Nov-2021
RSK-232	25-Nov-2021	IF there is an extreme prolonged weather conditions (heat/cold) THEN there is potential for wards/departments to be unable to maintain/provide effective service provision at required standards during prolonged extreme weather conditions	LEADING TO Service disruption/delays, Staff health & wellbeing, Patient safety, Adverse media publicity Breaches of Health & Safety at Work Act, Management of Health & Safety at Work Regulations, Workplace Health, Safety & Welfare Regulations	Organisation	Adam Biggs	18-Dec-2023	22-Apr-2024	Planned	12	12	12	Development and delivery of new national Adverse Weather and Health Plan to be implemented into EPRR Work Programme 2024 - to be signed off by Emergency Planning Steering Committee in February 2024. (18-Dec-2023)	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	Adverse Weather and Health measures will be revised prior to heatwave workshops by UKHSA in April	10-Apr-2022
RSK-254	26-Nov-2021	If Nursing staff do not follow the correct medication administration workflow, and do not scan the patient wristband... THEN patients could receive medication which is prescribed for another patient.	LEADING TO potential harm to patients	Organisation	Craig York	29-Nov-2023	01-Mar-2024	Planned	12	12	9	Drive adoption of CareAware Connect, including the support from senior Nursing Leadership. (04-Dec-2023)	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	29-Nov-2021	IF the Trust Fire Compartmentation are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices	Organisation	Michael Stark	27-Nov-2023	27-Mar-2024	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,	Low	Treat	Reviewed by Associate Director of Estates, Senior Engineer and Compliance Office. No change to current risk rating.	25-Aug-2021

Reference	Created on	Description		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	29-Nov-2021	IF the Trust Fire Doors are not regularly surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation	Michael Stark	27-Nov-2023	27-Mar-2024	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	Treat	Ongoing in house.	29-Nov-2021
RSK-269	30-Nov-2021	IF the Trust fails to comply fully with current DoH HTM 04-01 Parts A&B, Addendum relating to Water Systems and HTM 00 as identified in the Water Risk assessment THEN The Trust will be unable to provide assurance of a fully compliant water safety system	LEADING TO Increased risk to patients and staff, loss of reputation, financial loss to the Trust.	Organisation	Ben Hazell	20-Dec-2023	29-Mar-2024	Planned	16	12	8		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),	Low	Tolerate	reviewed by Associate Director of Estates, Estates Engineer, and Compliance Officer, no change to risk score.	21-Dec-2022
RSK-274	30-Nov-2021	IF the Trust worn flooring is not replaced THEN there is a risk of failure of flooring	LEADING TO trip hazard & infection control issues	Organisation	Paul Sherratt	20-Dec-2023	29-Mar-2024	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	Tolerate	Ward 7 and other remedials completed, change to tolerate, as ongoing monitoring.	25-Aug-2021

Reference	Created on	Description		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-281	30-Nov-2021	If the lift located in Outpatients (servicing levels 3, 4 of yellow zone, and Staff Health & Wellbeing) fails THEN disabled & mobility reduced/sight impaired individuals unable to access workplace or services – unable to fulfil contractual obligations. Persons entrapped in lift unable to exit. Delayed access/treatment of an individual taken ill whilst trapped. Claustrophobia, panic attacks, psychological harm, deterioration of condition	LEADING TO Reduced availability of staff, unable to carry out duties, reduced clinical input/unable to see clients (internal/external) in a timely manner – increased workload for other staff leading to increased work pressure/stress Loss of income of external clients who cannot be seen due to absence of clinician Service user dissatisfaction – complaints/reputation of service and organisation affected Adverse publicity if unavailability of service reported to local press/reputation of organisation and service affected The organisation would be in breach of statutory duties under Health & Safety At Work etc Act 1974, Equality Act 2010 – failure to provide safe access/egress/safe place of work – potentially leading to enforcement action/further interest of Health & Safety Executive Inspectorate	Organisation	David Field	27-Nov-2023	26-Feb-2024	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 (14-Nov-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	Business case approved but scope of work currently exceeds business case value. Project to be rescoped.	25-Aug-2021
RSK-424	25-Jan-2023	IF the new information standard regarding SDEC is released without significant operational and technical changes to the way the relevant information is collected THEN MKUH may not be able to submit the dataset in the required format with the required content LEADING TO a potential financial and reputational impact to MKUH	Potential financial, reputational, contractual, or operational impacts.	Organisation	Craig York	29-Nov-2023	01-Mar-2024	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	Discussions taking place with a view to run a project to deliver the SDEC workflow.	25-Jan-2023
RSK-425	25-Jan-2023	IF the current mechanisms used for reporting on RTT status continue, along with the current use (and third-party support) of the tools to populate PTL reporting, pathways can 'drop' from the PTL due to legacy logic and rules deeply embedded in the PTL build to cleanse the PTL THEN the data available for submission will continue to require significant overhead to review, rectify and improve (i.e. veracity etc.) LEADING TO an inability to submit with short turnarounds, continued challenges in seeing patient pathways, prioritizing care etc. and potentially a risk to patient safety as a result.	Potential impact to patient care due to an inability to see patient pathways at a system level.	Organisation	Craig York	29-Nov-2023	01-Mar-2024	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	Work focused on waiting list management continues. PTL tool management continues to improve with greater understanding of how the data flows into the tool. Outcome form solution due to improve the quality of the data by next review, at which point this risk may be rated lower.	25-Jan-2023
RSK-007	06-Sep-2021	IF the team Fire Warden is not adequately trained or they are not present during a related emergency; THEN there would be no focal point for fire safety matters for local staff and supporting line managers on fire safety issues, and the team may not be represented in Fire Safety Committee meetings, and they will not be able to organise and assist in the fire safety regime within their local area	LEADING TO staff and other individuals visiting level 1 in Oak House potentially not being evacuate in a timely manner due to the lack of oversight. The lack of single focused oversight could cause confusion, delays in evacuation and people being left behind. This could lead to smoke inhalation, burns, death. Fire checking and prevention procedures may not be robust enough to identify potential hazards and prevent a fire from happening. Breach of statutory regulations	Organisation	Tina Worth	15-Nov-2023	31-Mar-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	Low	Treat	Risk reviewed. Fire information v3 shared with all of team & acknowledgment form completed & returned to Anna Bignall	06-Sep-2021
RSK-242	26-Nov-2021	IF a chemical, biological, radiological, nuclear (CBRN/HAZMAT) incident was to occur through either intentional or unintentional means THEN the Trust would require specialised response through national guidelines and expert advice	LEADING TO potential impact on Trust services and site safety to patients and staff; Possible impact on closing or disrupting ED operations, with further risk to all operations on how the Trust operate depending on the nature of the incident (e.g., Novichok incident at Salisbury)	Organisation	Adam Biggs	18-Dec-2023	19-Feb-2024	Planned	10	10	5	The outstanding areas identified in South Central Ambulance Service bi-annual audit will be incorporated into revising the CBRN SOP and training programme to be embedded with MKUH EPRR Work Programme 2024. This programme will be presented at the Emergency Planning Steering Committee in February 2024 for sign-off. (18-Dec-2023)		Low	Treat	Review of risk following updates made to CBRN planning arrangements taken from SCAS september 2023 bi-annual report.	26-Nov-2021

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RSK-260	29-Nov-2021	IF people working at height are not correctly trained THEN there is a risk from fall from height	LEADING TO staff/contractor injuries, potential claims, non compliance with statutory regulations and loss of reputation	Organisation	Paul Sherratt	20-Dec-2023	29-Mar-2024	Planned	15	10	5	Refresher Ladder Training to be arranged and delivered. Quote to be obtained from Alan Hambridge. (20-Sep-2023), Manual alternative to Cherry Picker to be sourced.	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, Estates Engineer, and Compliance Officer, no change to risk score.	25-Aug-2021
RSK-010	06-Sep-2021	IF the Radar Risk Management System does not meet the needs to the Trust and of legal reporting requirements THEN the Trust will not have an appropriate system to manage incidents, complaints, claims, compliments, safety alerts, 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	03-Jan-2024	02-Feb-2024	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 changes to this risk.	28-Apr-2021
RSK-033	27-Sep-2021	If the laundry contractor (Elis) can not provide an efficient and effective service. Then there may be: Delayed deliveries from Elis 2. Shortage deliveries from Elis 3. Lack of contingency stock	Leading to: 1. Delayed linen distribution throughout the trust. 2. Delayed personal care – negative impact on patient experience. 3. Delayed clinics and surgical lists (theatres). 4. Staff health and wellbeing – stress. 5. Waste of staffing resources – staff without linen to distribute. 6. In case of a Major Incident there would not be enough laundry to provide a good level of patient care.	Organisation	Steven Hall	22-Nov-2023	22-Feb-2024	Planned	8	9	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	Treat	Monthly Review Meeting with the contractor - Daily Issues log started - to be discussed at the monthly reviews	01-Dec-2022
RSK-215	24-Nov-2021	IF Child Protection (CP) Medicals are not completed THEN there is potential for delay in proceedings for Child Protection which may lead to compliance issues for the Trust and impacts on children, families and staff	LEADING TO legal and regulatory issues for MKUH, the police, and Social Services. Delays in appropriate multi-agency safeguarding children actions being taken and potential for increased risk to the child's safety and potential litigation against the Trust	Organisation	Julie Orr	09-Nov-2023	08-Dec-2023	Overdue	9	9	6	Head of safeguarding and Named Doctor to review the CP medical internal MKUH process for booking CP medicals and data capture as part of gap analalysis (09-Nov-2023), Ongoing discussions are being held with BLMK and CNWL and Designated Doctor to progress toward an agreeable pathway (09-Nov-2023)	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	Treat	Discuss with the Head of safeguarding and the designated doctor	24-Nov-2021

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RSK-216	24-Nov-2021	If agreed safeguarding processes/ practice and staffing are not in place which includes multi-agency working and information sharing THEN the Trust may be non-compliant with key regulatory and legislative processes including information-sharing agreements.	LEADING TO potential failures in care provision which may have a detrimental effect on patients, their families, staff, and the Trust. The complexities of multi-agency working especially within safeguarding require information sharing between multiple agencies. Currently, there are multiple pathways for sharing of information. Failure to comply with regulations/legislation and information-sharing processes has potential legal and financial implications for the Trust.	Organisation	Julie Orr	09-Nov-2023	08-Dec-2023	Overdue	9	9	6	Ongoing training programme for all staff (09-Nov-2023), Named leads -staff development and training in safeguarding roles	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),	Low	Treat	Review risk with the Head of Safeguarding	24-Nov-2021
RSK-233	25-Nov-2021	IF we are unable to recruit sufficient staff THEN we may not have safe staffing levels in the hospital	LEADING to reduced service delivery, reduction in patient experience and care.	Organisation	Louise Clayton	24-Nov-2023	31-Jan-2024	Planned	16	9	3	Recruitment plans by role (18-Oct-2023), Recruitment Specialists (24-Nov-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	25-Nov-2021	IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover	LEADING TO clinical risk. Increasing temporary staffing usage and expenditure Increased turnover Decreased stability rates Increased stress levels within trust Reduced morale	Organisation	Louise Clayton	18-Oct-2023	31-Dec-2023	Overdue	16	9	9	Creation of retention toolkit (24-Nov-2023), Review of Exit Interview process (24-Nov-2023), Review of local induction/onboarding process (24-Nov-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	Low	Tolerate	Risk Reviewed - Controls updated. No change to Risk Score	02-Jan-2023

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RSK-276	30-Nov-2021	If the flat roofs identified in the Langley Roof report and 6 facet survey as requiring replacement or upgrading, are not replaced THEN there is a risk of roof failure in relation to flat roofs across the Trust	LEADING TO Water ingress - Potential damage to equipment, disruption to service, damage to reputation	Organisation	Anthony Marsh	20-Nov-2023	31-Mar-2024	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
RSK-279	30-Nov-2021	IF pedestrians in the hospital grounds walk over the verges, grassed areas, mounds, slopes, sloped/high curbs and do not stick to the designated pathways THEN Patients, visitors and staff could slip, trip or fall causing injury including fractures, sprains, strains	LEADING TO legal and enforcement action against individuals/and or the Trust leading to fines/compensation/exposure in local press leading to adverse publicity	Organisation	Michael Stark	18-Dec-2023	18-Mar-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	30-Nov-2021	IF there is a lack of on-site appointed person for decontamination - AP (D) THEN the Trust will not be able to implement and operate the Management's safety policy and procedures relating to the engineering aspects of decontamination equipment	LEADING TO non-compliant machines – working but not correctly; machine Failures – suddenly unusable, loss of production, out-sourcing; equipment released that is not disinfected or sterile – risk to staff; equipment released that contains endotoxins – risk to patients / SSI's	Organisation	Michael Stark	18-Dec-2023	18-Mar-2024	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	30-Nov-2021	IF medical equipment is damaged due to misuse, inappropriate use, storage, transportation, and/or inappropriate cleaning THEN the medical equipment may be unavailable due to damage	LEADING TO delay in patient care and treatment; cost of parts; cost of repairs; purchasing replacement	Organisation	Ayca Ahmed	21-Dec-2023	21-Jan-2024	Planned	12	9	9		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	Tolerate	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-284	30-Nov-2021	IF staff members do not adhere to the Medical Devices Management Policy THEN they may not follow the correct procurement procedures for Capital and Revenue medical equipment purchases	LEADING TO them being not fit for purpose equipment being purchase; more costly; non-standardised; lack maintenance contract; lack of training for staff; incompatible/lack of consumables and accessory; additional IT integration costs	Organisation	Ayca Ahmed	22-Dec-2023	22-Jan-2024	Planned	12	9	6	Checklist for procurement team to make sure prior to purchase they liaise with the MEM team (21-Dec-2023)	Medical Devices Group meetings are held monthly to discuss procurement(01-Jul-2022), BC review for capital medical equipment purchase(18-Dec-2023)	Low	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	16-Oct-2018
RSK-300	30-Nov-2021	IF the call bell system is not replaced/upgraded THEN the call bell system could fail as parts obsolete for some systems to obtain	LEADING TO increased risk to patients and possible service disruption and poor patient experience	Organisation	David Field	20-Dec-2023	29-Mar-2024	Planned	9	9	3	Wards with obsolete equipment require replacement. Upgrade programme to be included in rolling Capital bid (03-May-2023)	An emergency back up system of 30 units has been purchased in the event of current system failing. There is also an additional spare unit(30-Nov-2021), Ward 4, 5 and Milton Mouse & A&E Majors were replaced in FY18/19(30-Nov-2021), ADAU replaced as emergency business case October 2019(30-Nov-2021), Endo replaced in Jan 2020(30-Nov-2021), Vizcall no longer in business, plan to replace all Vizcall systems in 20/21 - Vizcall test equipment and spares purchased for in house support(30-Nov-2021), Above the line funding for 2 x wards and ED agreed for 2021 with Ascom. Ward 2A and ED will be completed in 2023/2024(30-Nov-2021)	Low	Treat	reviewed by Associate Director of Estates, Estates Engineer, and Compliance Officer, no change to risk score.	25-Aug-2021

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RSK-432	10-Feb-2023	IF the Trust does not effectively communicate with its patients (e.g. for visually or hearing impaired patients/family members or those where English is not their first language etc) THEN some patients will not be able to access information relating to their care and treatment	LEADING TO patients/families not being effectively included in decisions relating to their care; the Trust not being compliant with the Accessible Information Standards	Organisation	Tasmane Thorp	14-Nov-2023	14-Dec-2023	Overdue	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	10-Feb-2023	IF there is insufficient capacity of outpatient appointments THEN Patient Access will be unable to provide patients within designated timescales	LEADING TO a delay in diagnosing and treating patients; cancellation of appointments to ensure patients are appropriately prioritised; increasing waiting lists; breach in national appointment timescales; patients being moved in clinics without clinical validation.	Organisation	Emma Hunt-Smith	14-Nov-2023	14-Dec-2023	Overdue	9	9	6	Cleanse of the Patient Tracking Lists for the following services to be undertaken, utilising additional non-recurrent resource - Ophthalmology; ENT; Urology; Trauma & Orthopaedics; Gynaecology (05-Dec-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), Capacity & Demand planning for all services to be completed(10-Feb-2023)	Low	Treat	Impact of Risk - Update added (Patients being moved in clinics without clinical validation), requested by Jessica Goodger, approved by Felicity Medina @ Patient Access Managers meeting 15 May 2023	06-Feb-2023
RSK-448	17-Apr-2023	IF the GE Voulson E10 obstetric ultrasound machines are more than 5 years old THEN there may be reduced accuracy in imaging and reduction in image quality; ongoing further costing to replace probes and complete maintenance; higher risk of equipment breakdown	LEADING TO potential unnecessary further testing and patient stress; potential withdrawal from service and cancelation of lists; breach of Public health England's Fetal anomaly screening programme (FASP) guidance	Organisation	Alexandra Godfrey	12-Dec-2023	31-Jan-2024	Planned	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	OPU2 ultrasound machine relocated to ANC2.	21-Mar-2023
RSK-020	22-Sep-2021	IF there are ligature point areas in ED for Adult and C&YP in all areas of department THEN ED patients may use ligature points to self harm. There has been an incident where a mental health patient used a door closer as a ligature point.	LEADING TO increased safety risk to patients, safe and adverse publicity	Organisation	Kirsty McKenzie-Martin	04-Dec-2023	08-Jan-2024	Pending	9	8	1	Mental Health pathway to be reviewed by the Corporate Team (04-Dec-2023)	Patients assessed and those at risk of self harming are placed in an area they can easily be observed.(22-Sep-2021), New mental health room has been ligature and risk assessed by CNWL team(22-Sep-2021), Remind all staff about keeping swipe doors closed so they don't access rooms where they are not observeble Last ligature audit was April 2019 and actioned.(22-Sep-2021), Risk Assessment of adult and C&YP areas reviewed April 2019(22-Sep-2021), Check list in place to risk asses each Adults and C&YP attending with MH/DSH issues to identify personalised action plan(22-Sep-2021), Follow up ligature RA completed as advised by H&S lead for trust Risk Assesment completed - identified need for collapsible clothes hangers in public toilets - request to estates to install and completed; x1 non-compliant cord pull also in toilet - changed(22-Sep-2021), Repeat Ligature Risk Assessment for 2020 required(22-Sep-2021), ensure all staff are aware of the new Policy - "Ligature Risk Awareness"(22-Sep-2021), 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

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RSK-262	29-Nov-2021	IF the Trust Fire Dampers are not surveyed and remedial works funded THEN remedial work not being completed	LEADING TO the travel of fire between compartments causing risk to life, greater damage to the estate, poor public image and subsequent interventions from the Fire Brigade with potential enforcement notices.	Organisation	Michael Stark	27-Nov-2023	27-Feb-2024	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	Annual servicing and maintenance being arranged by David Baker and ongoing.	25-Aug-2021
RSK-265	30-Nov-2021	IF there is local power failure and failure of emergency lights, due to age of existing fittings and lack of previous investment THEN there may be a failure to protect persons allowing a safe evacuation of the area	LEADING TO poor patient experience and safety, non-compliance with regulation, loss of reputation	Organisation	David Field	20-Dec-2023	29-Mar-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, Estates Engineer, and Compliance Officer, no change to risk score.	25-Aug-2021
RSK-266	30-Nov-2021	IF the Trust are unable to take up the New Hospital Plan THEN The Trust would have to fund all future developments from either internally generated funding defined for backlog investment or borrow the money	LEADING TO the Trust being unable to meet the needs of the future MK population with regard to the size and quality of the estate	Organisation	Rebecca Grindley	19-Dec-2023	14-Apr-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	30-Nov-2021	IF the existing surface water drainage system is not suitably maintained or repaired THEN the surface water drainage system could fail	LEADING TO flooding and contamination and loss of service	Organisation	Michael Stark	18-Dec-2023	15-Mar-2024	Planned	12	8	4	Annual drain survey scheduled to identify remedial works (31-Mar-2023)	Reactive maintenance repairs(30-Nov-2021), CCTV works has indicated areas of root re-growth with pipe damage to storm water pipes, works being undertaken during summer/autumn 2021(30-Nov-2021), BDP created scope for full site survey under the HIP program to identify shortfall in current data and future plan requirements. A new link is likely to be required as part of South Site development(30-Nov-2021), Road Gulley on PPM(30-Nov-2021)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	25-Aug-2021
RSK-293	30-Nov-2021	IF the current fuse boards are not updated to miniature circuit breakers THEN existing fuse-boards could fail	LEADING to delays in repairs/replacement resulting in possible service disruption and poor patient experience	Organisation	David Field	20-Dec-2023	29-Mar-2024	Planned	12	8	4	Ongoing rolling program of refurbishment, subject to funding in Trust Capital programme (23-Mar-2023)	PPM testing and repairs(30-Nov-2021), Fixed electrical testing program in place to identify any potential risks and actions required(30-Nov-2021), Replaced Circuit breakers/fuses FY 20/21(30-Nov-2021), Ward 1 completed 2021(30-Nov-2021), Wards 15 & 16 have replacement circuit boards fitted as part of ward refurbishment in 2022(21-Dec-2022)	Low	Treat	reviewed by Associate Director of Estates, Estates Engineer, and Compliance Officer, no change to risk score.	25-Aug-2021
RSK-301	30-Nov-2021	IF the existing foul water drainage system is not suitably maintained or repaired THEN the system could fail	LEADING TO cause flooding, contamination and loss of service	Organisation	Michael Stark	18-Dec-2023	20-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

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RSK-005	06-Sep-2021	IF policies, guidelines and patient information are not reviewed and amended in a timely manner; THEN staff will be working with out of date information	LEADING TO potential error in patient care, non-compliance with legislative, national requirements, potential litigation and potential loss of reputation to Trust	Organisation	Tina Worth	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	29-Oct-2021	IF annual and quarterly test reports for Autoclaves and Washer Disinfectors used for critical processes are not being received in a timely manner from the Estates department and there is no Authorised Person (D) to maintain the day to day operational aspects of the role THEN the Trust will be unable to prove control, monitoring and validation of the sterilisation process as a control measure. Both units are reviewed only 1 day per month - a bulk of this time is spent checking records and the other aspects of the role do not get the sufficient time required to review and follow up.	LEADING TO possible loss of ISO 13485 accreditation due to non-compliance to national standards. Inconsistent checks or lack of scheduled tests for the steam plant also increase the risk.	Organisation	David Baker	20-Dec-2023	27-Dec-2024	Planned	20	6	6		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), AE(D) to appoint AP(D) for Endoscopy.(20-Sep-2023)	Low	Tolerate	corrected target score to 6, updated risk appetite to tolerate, as no further controls are required.	25-Aug-2021
RSK-204	23-Nov-2021	IF data sent to external agencies (such as NHS Digital, Advise Inc and tenders) from the Procurement ordering system contain patient details THEN there is a risk that a data breach may occur with reference to GDPR and Data Protection Act as the procurement department deals with large volumes of data.	LEADING TO a data breach and potential significant fine	Organisation	Lisa Johnston	12-Dec-2023	12-Jan-2024	Planned	16	6	6		All staff attend an annual mandatory training course on Information Governance(23-Nov-2021), Staff are encouraged to use catalogues which reduces the requirements for free text(23-Nov-2021), Data sent out to external agencies is checked for any patient details before submitting(23-Nov-2021)	Medium	Tolerate	Ongoing risk	01-Apr-2022
RSK-205	23-Nov-2021	IF there is Incorrect processing through human error or system errors on the Procurement systems THEN there is risk that there may be issues with data quality within the procurement systems	LEADING TO Incorrect ordering resulting in a lack of stock and impacting on patient safety	Organisation	Lisa Johnston	12-Dec-2023	12-Jan-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	23-Nov-2021	IF there is major IT failure internally or from external providers THEN there is a risk that key Finance and Procurement systems are unavailable	LEADING TO 1. No Purchase to pay functions available ie no electronic requisitions, ordering, receipting or payment of invoices creating delays for delivery of goods. 2. No electronic tenders being issued. 3. No electronic raising of orders or receipting of income	Organisation	Karan Hotchkin	12-Dec-2023	12-Jan-2024	Planned	12	6	6		If its an external issue, SBS the service provider of the purchase to pay and order and invoicing has a business continuity plan in place(23-Nov-2021), If its an internal issue. The Trust has arrangements with the CCG who also use SBS to use their SBS platform(23-Nov-2021)	Medium	Tolerate	Risk transferred from Datix	01-Apr-2022
RSK-209	23-Nov-2021	IF staff members falsely represent themselves, abuse their position, or fail to disclosure information for personal gain THEN the Trust/Service Users/Stakeholders may be defrauded	LEADING TO financial loss and reputational damage	Organisation	Karan Hotchkin	12-Dec-2023	12-Jan-2024	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

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RSK-211	23-Nov-2021	IF infection / colonisation with pseudomonas aeruginosa from contaminated water occurs within the Cancer Centre THEN there is a risk of infection and complications this could cause to immuno-suppressed cancer patients. Mitigations in place to avoid risk to patients and staff in Cancer Centre	LEADING TO susceptible patients within augmented care units such as Ward 25 and chemotherapy Suite potentially coming to harm	Organisation	Angela Legate	27-Dec-2023	22-Jan-2024	Pending	16	6	6		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-238	25-Nov-2021	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	27-Nov-2023	31-Dec-2023	Overdue	12	6	6	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), Set up standing agenda for Manual Handling Steering Group(18-Oct-2023)	Low	Treat	Risk reviewed - Controls updated	01-Nov-2021
RSK-252	26-Nov-2021	IF eCARE does not prevent non-prescribers from prescribing medication which could then be administered to a patient THEN there could be limitations in restricting access to individual Smart Card holders permissions or individuals do not adhere to the correct workflow	LEADING TO Medications could be prescribed and administered to a patient that are not clinically required & could be contraindicated	Organisation	Craig York	29-Nov-2023	01-Mar-2024	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	29-Nov-2021	IF the Switchboard resources cannot manage the service activity THEN this may result in poor performance	LEADING TO failure To meet KPI's and Emergency Response Units will put Patients, Staff and Visitors at risk and Communication with Users will give poor perception of the We Care action initiative	Organisation	Alan Brooks	20-Dec-2023	29-Mar-2024	Planned	20	6	3	Review of staff rota profile with Security Manager and Switchboard Manager to confirm current status, If adequate then change the risk profile to tolerate. (20-Dec-2023)	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)	Low	Treat	reviewed by Associate Director of Estates, Estates Engineer, and Compliance Officer, no change to risk score.	25-Aug-2021
RSK-272	30-Nov-2021	IF the Passenger Lifts are not maintained THEN there is a risk of failure of components	LEADING to malfunction. Patients or visitors could get stuck in the lift, this could potentially cause panic or delay treatment. The public image of the trust could be affected.	Organisation	David Field	14-Nov-2023	14-Nov-2024	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	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-273	30-Nov-2021	If the Trust Wards and Departments fail to demonstrate their medical equipment is maintained to correct standards THEN there is a risk of the Trust not complying with CQC Regulation 15 Premises and Equipment and risk to patient care	LEADING TO non-compliance and negative impact on the reputation of the Trust	Organisation	Ayca Ahmed	18-Dec-2023	18-Jan-2024	Planned	15	6	3	Contract KPI's agreed as part of new contract (18-Dec-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	30-Nov-2021	IF the Summary Record of Estates 5 year and Prioritised Backlog Maintenance risk based priority programme is not fully implemented THEN plant and equipment may fail in various areas of the hospital	LEADING TO infection control, financial implications, loss of services and reputation damage	Organisation	Anthony Marsh	23-Mar-2023	31-Mar-2024	Planned	9	6	4	Ongoing reviews, identified backlog issues driving Capital Plan. Outstanding funding of Capital works required. Operational impact of significant works to be considered. (02-Nov-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), New Hospital Programme guidance indicates funding to clear CIR backlog programme to be included as part of the project.(01-Jul-2022)	Low	Treat	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	25-Aug-2021
RSK-217	24-Nov-2021	IF patients are unable to meet their nutritional requirements orally nasogastric tube feeding may be required to meet their nutritional needs; staff may not be confident or competent passing Nasogastric Tubes (NG Tubes) or correctly confirming the position of the Nasogastric tube tip THEN there is a risk that Nasogastric (NG) Feeding Tubes are not inserted and/or positioned correctly	LEADING TO 1) A Never event if feed/medication or water are inserted into the nasogastric tube and it is incorrectly positioned in the lung. This could result in death. 2) Patients would experience a delay in feeding if staff are not competent placing nasogastric tubes and checking the position of the tube tip.	Organisation	Jane Radice	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	Created on	Description		Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-120	29-Oct-2021	IF medical devices are not correctly cleaned/disinfected/decontaminated/sterilised THEN the devices will not be sufficiently cleaned	LEADING TO possible patient and staff safety issues and cross contamination	Organisation	Marea Lawford	14-Mar-2023	03-Jan-2024	Pending	9	4	4	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. (02-Jan-2024), monitor and increase score should it be required to do so. this is not seen as a likely risk (02-Jan-2024)		Low	Tolerate	risk is low and deemed acceptable.	05-Jan-2023
RSK-160	12-Nov-2021	IF the existing Bag Valve Masks (BVM) look similar to the Lung Volume Recruitment (LVR) bags that the department want to introduce as a Physiotherapy treatment modality for airway clearance THEN they could be used in error during resuscitation procedures	LEADING TO patient requiring resuscitation with a BVG could have resuscitation attempted with a LVR bag and could suffer consequences of incorrect treatment initially and delay to correct treatment procedures	Organisation	Adam Baddeley	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	Low	Tolerate	No changes to risk score, continue to review 3 monthly. No incidents identified.	17-Jan-2020
RSK-237	25-Nov-2021	IF the Trust is unable to spend the full amount of the Apprenticeship Levy each month THEN money which could have been used to develop our staff will be forfeit	LEADING failure to maximise taxpayers money. The Trust may not be able to use the apprenticeship levy to fund staff education, training and development. Inability to maximise the new apprenticeship standards may impact on recruitment, retention and career development	Organisation	Louise Clayton	18-Oct-2023	31-Dec-2023	Overdue	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 (24-Nov-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	29-Nov-2021	IF adequate PAT testing is not carried out in a systematic and timely manner THEN untested faulty equipment could be used	LEADING TO poor patient and staff safety and increased claims against the Trust	Organisation	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	Created on	Description		Scope	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-288	30-Nov-2021	IF the medical oxygen supply fails to function or becomes non-compliant with HTM requirements THEN the oxygen plant may not be available	LEADING TO potential loss of service, reduced patient safety and substandard care	Organisation	Michael Stark	23-Jun-2023	31-Mar-2024	Planned	12	4	4		PPM Schedule, and reactive repairs as required(30-Nov-2021), Robust contingency plan is in place with liquid O2(30-Nov-2021), Steve Goddard has been appointed as Authorised Engineer(30-Nov-2021), Estates Officer has been appointed as AP(30-Nov-2021), SHJ appointed as maintenance contractor(30-Nov-2021), AP training booked for and additional estates officer and estates service manager(30-Nov-2021), VIE capacity upgrade 2021(30-Nov-2021), Draft feasibility to achieve second VIE, and conversion of site to ring main, linked to HIP programme(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates, Estates Manager, and Compliance Officer - No change to rating.	25-Aug-2021
RSK-294	30-Nov-2021	IF staff do not carry out either informal (i.e. experience-based) or formal risk assessments before attempting a work task THEN there is a risk of personal injury to staff carrying out routine work	LEADING TO poor staff safety, injury and financial loss	Organisation	Michael Stark	23-Mar-2023	31-Mar-2024	Planned	12	4	4		All staff receive formal risk assessment training, and are competency assessed for their roles. Independent External Advisor contractor commissioned to review estates risk assessments and arrangements regularly.(30-Nov-2021), Risk awareness training is performed annually along with asbestos awareness training for all workshop staff as part of the H&S training package(30-Nov-2021), Training plan updated and implemented(30-Nov-2021), Risk Assessments by task type pop up on MICAD PPM tasks for workshop staff.(30-Nov-2021), Weekly huddle meeting with maintenance staff to include H&S(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	30-Nov-2021
RSK-295	30-Nov-2021	IF there is a lack of knowledge on use or poor condition of ladder THEN there is a risk of fall from height from ladders	LEADING TO risk of harm to staff, poor public image, a potential investigation by HSE	Organisation	Paul Sherratt	23-Mar-2023	31-Mar-2024	Planned	12	4	4		Staff issued with safe use of ladder guidance(30-Nov-2021), Ladder inspections PPM schedule in place to check(30-Nov-2021), New replacement ladders have been installed, tagged and registered(30-Nov-2021), A competent training person needs to be identified to provide continual training(30-Nov-2021), RP Appointed(30-Nov-2021)	Low	Tolerate	Reviewed by Associate Director of Estates & Compliance Officer. No change to current risk rating.	30-Nov-2021
RSK-402	01-Dec-2022	IF there is a lack of Orthopaedic Therapy staff to provide rehabilitation, discharge planning and equipment to patients in the trauma and elective orthopaedic pathways. THEN fractured NOF patients may not be able to be offered daily mobilisation; may not have a functional OT assessment within 7 days; elective Orthopaedic patients may not be seen twice a day	LEADING TO potential for length of stay for both trauma and elective patients to increase and reduce patient experience.	Organisation	Adam Baddeley	19-Dec-2023	31-Jan-2024	Planned	15	4	3	Pathway review (13-Nov-2023)	Recruitment of vacant posts(01-Dec-2022), Recruitment(01-Dec-2022)	Low	Treat	All posts are appointed to, with x2 waiting to start, all other posts are in and working.	01-Dec-2022
RSK-008	06-Sep-2021	IF the Trust does not have an appropriate system to record mortality and morbidity data; THEN the Trust will not be able to record and/or provide accurate reports for governance or the Trust Board	LEADING TO non-compliance with the National Mortality & Morbidity 'Learning from Death' Framework	Organisation	Nikolaos Makris	14-Nov-2023	25-Dec-2023	Overdue	15	2	2		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	Tolerate	Upgraded IT mortality tracking solution expected to be functional by Dec 23	06-Sep-2021

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RSK-016	22-Sep-2021	IF there is a lack of flow in the organisation THEN there may be an unsafe environment for patients	LEADING TO a potentially impact on bed space capacity, ambulance queues, missed Emergency Access Targets and overcrowding into ED/radiology corridors creating Health & Safety hazard and continued pressure, leading to poor patient care/treatment, nursing patients outside of cubicles in corridors and the middle of majors,and delays in discharge/transfer and the potential for an increase of incidents being reported regarding assessment/care/treatment, and or significant number of patients with a high acuity/ dependency being cared for in areas that are not suitable for safe care	Organisation		Kirsty McKenzie-Martin	04-Dec-2023	08-Jan-2024	Pending	25	20	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-107	26-Oct-2021	IF uterine artery doppler are not performed for pregnant women who meet the criteria according to SBLv3 THEN there will be non-compliance with the recommendations by the Saving babies Lives bundle V3	LEADING TO pregnant women with HIGH RISK factors for fetal growth restriction who are at increased risk of perinatal mortality if there is failure to recognize increased risk of & fetal growth restriction and failure to serially scan them from 28 weeks; There will be missed opportunities to discuss high risk cases for early input with fetal medicine team	Region	Women's Health	Faryal Nizami	13-Dec-2023	29-Feb-2024	Planned	16	20	6	Complete 3 months of audits for assurance that implementation has been successful	We are offering serial scans from 28 weeks to all high risk women which has put significant pressures on demand and capacity of the ultrasound department.(26-Oct-2021), Sonographers to be trained in UAD scanning(27-Apr-2022), Review with Obs and USS when in the service the dopplers will be implemented(12-Oct-2022), Obs USS SOP to be updated to align with fetal growth assessment guideline(07-Mar-2023)	Low	Treat	No change to risk.	24-May-2021
RSK-110	26-Oct-2021	IF MKUH does not have a dedicated maternity triage area separated from ADAU, with dedicated staffing. THEN calls are answered by a variety of staff and in times of high activity, calls are missed, the staff that are answering the calls are being taken away from other competing priorities AND Delays to triage and ongoing care to service users And Delays to ADAU service users.	LEADING TO service users not being able to access advice resulting in delayed presentation; potential financial risk to the trust should adverse outcomes occur as a result; service users not being triaged and assessed for urgency of clinical need resulting in delayed assessment and possible adverse outcome; Day assessment users being seen alongside triage users results in delays of care with increased risk of poor outcomes and missed care. Poor experience leading to and increase complaints	Region	Women's Health	Natalie Lucas	15-Dec-2023	29-Feb-2024	Planned	16	20	6	Compliance to new pathway audit (15-Sep-2023), Assess feasibility of moving ADAU into a separate area from triage with costing, Review staffing establishment for triage and ADAU to create separate establishment., Review staffing establishment for triage and ADAU to create separate establishment., Review opening hours for ADAU to assess feasibility for increased opening hours, Identify and create area for telephone triage which is away from the acute triage area, Review obstetric contact for triage and ADAU to ensure timely escalation and review of patients, GAP triage guideline with recent RCOG triage best practice, Review sluice area to have adequate space for testing such as PiGF and FFN, Review sluice area to have adequate space for testing such as PiGF and FFN, Review and plan for 90% of all inpatient staff to be BSOTS trained.	1. Currently unable to staff a dedicated phoneline(26-Oct-2021), 2. RAG rating in place to mitigate current lack of formal maternity triage system(26-Oct-2021), BSOTS was partially put in place and is being audited weekly.(26-Oct-2021), Triage band 7 post to be advertised(12-Apr-2022), Submit business plans for change to the area to support the implementation of triage(27-Apr-2022), Implement MEOWs into maternity(27-Apr-2022), Review the staffing model(27-Apr-2022), Risk assessment to be performed in relation to Triage to understand if the implementation has been successful or if further changes are required(13-Nov-2023), Risk assessment to be performed in relation to Triage to understand if the implementation has been successful or if further changes are required(13-Nov-2023)	Low	Treat	Update to risk and increase to score due to ongoing incidents in relation to triage. New actions added to risk.	06-Sep-2021
RSK-131	04-Nov-2021	IF the cross-sectional imaging demand continues to increase for CT, MRI and ultrasound. THEN image acquisition and report generation turnaround times will significantly be delayed. This is due primarily from a lack of staffing capacity rather than equipment capacity.	LEADING TO delayed diagnosis and treatment with ultimately poorer patient health outcomes. As well as reputational damage due to long patient imaging waits and financial penalties being incurred from the department of health due to a lack of adherence to internal KPI'S and more importantly DMO1 national imaging datasets. Imaging team members also being affected and decreasing recruitment and retention ability due to pressurised working conditions. Pertaining to cancer pathways, potential increase in the required treatment, potential poorer prognosis for patient, poor patient experience, increase in complaints and litigation cases.	Region	Diagnostic & Screening	Paula Robinson	24-Nov-2023	19-Dec-2023	Overdue	20	20	9	Business Case to be developed for Radiographers (24-Nov-2023), Review of Radiologists - demand and capacity (24-Nov-2023), Recruitment of staff (24-Nov-2023)	Extended working hours and days(04-Nov-2021), Some scans sent off site to manage demand(04-Nov-2021), Reduced appointment times to optimise service(04-Nov-2021), New CT Machine to be implemented(19-Apr-2022)	Low	Treat	Risk remains high. Service is reliant on agency to support service. Increased demands on service and workload pressures. Unable to meet demand with current capacity mostly due to staffing deficit.	01-Jun-2021

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RSK-134	04-Nov-2021	If there is insufficient funding, then the Trust may be unable to meet financial plans and targets or deliver its strategic aims,	Leading to service failure and regulatory intervention THEN the Trust will be unable to meet its financial performance obligations or achieve financial sustainability	Organisation		Karan Hotchkin	12-Dec-2023	12-Jan-2024	Planned	20	20	8	Medium Term financial modelling commenced with ICS partners. (20-Nov-2023), Work with ICS partners and NHSE to mitigate financial risk.	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-	High	Treat	Risk transferred from Datix	01-Apr-2022
RSK-202	23-Nov-2021	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-Dec-2023	12-Jan-2024	Planned	20	20	8	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 £9.2m as the end of Oct 223 have been identified against the £17m target. Whilst this shortfall can be mitigated this year, the risk is around the underlying financial position. (20-Nov-2023)	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)	Medium	Treat	Risk transferred from Datix	01-Apr-2022
RSK-305	06-Dec-2021	If there is insufficient strategic capital funding available THEN the Trust will be unable to invest in the site to maintain pace with the growth of the Milton Keynes population's demand for hospital services	LEADING To financial loss and reputational damage	Organisation		Karan Hotchkin	12-Dec-2023	12-Jan-2024	Planned	16	20	10	Trust is discussing this with the regional Capital Team and with the ICB capital allocations for 23/24. (20-Nov-2023)	The trust has a process to target investment of available capital finance to manage risk and safety across the hospital(06-Dec-2021), 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-374	23-Aug-2022	IF patients on the cancer pathway wait longer than 62 days THEN there is the risk treatment has been delayed,	LEADING TO potential harm a risk of potential harm physical or psychological or both	Region	Haematology & Oncology	Sally Burnie	19-Dec-2023	31-Mar-2024	Planned	12	20	8	weekly restore and recovery clinical meetings and weekly operational meetings (13-Jun-2023)		Medium	Treat	Risk continues as high due to current cancer performance and harm review processes in place, ADOs and Execs aware and performance reports produced for TEC	05-Aug-2022

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-409	13-Dec-2022	IF the demand within the ED department outweighs the departments capacity THEN there could be increased waiting times for patients to be seen; there could be increased triage times, privacy and dignity of patients may be compromised; there could be increased violence and aggression towards health care providers; long length of stay for specialty patients in ED; delayed ambulance handover	LEADING TO medical condition being exacerbated with delayed treatment/hospitalisation/death; privacy and dignity compromised, poor patient experience leading to complaints/claims; vulnerable adults on trolleys in corridor in majors; Lack of space to hoist patients' safety, lack of dignity and respect in hoisting patients in middle of department ;Increase risk of stress and morale burnout of staff due to an inability to give basic nursing care to patients; Trapped in the event of incident/insufficient space to evacuate promptly leading to potential physical injury; Nurses do not have the necessary specific skills or competence to monitor speciality patients in ED such as oncology, Cardiac, gynaecological, endocrinology and acute care of the elderly patients requiring increased enhanced observation; the Trust may receive increased complaints, claims/litigation, enforcement leading to financial penalties/enforcement notices – breaches of Health & Safety at Work etc Act 1974, Manual Handling Operations Regulations 1992, Management of Health & Safety at Work Regulations 1999, Workplace Health Safety & Welfare Regulations 1999; Trust may be in breach of RCEM guidance; negative affect on recruitment and retention - low levels of staffing	Region	Emergency Department	Kirsty McKenzie-Martin	04-Dec-2023	08-Jan-2024	Pending	15	20	6	Review mental health pathways (04-Dec-2023), Reviewing specialist pathways to support flow within ED department (30-Jun-2023), Ongoing Training needs analysis to identify gaps in knowledge (08-Nov-2023)	Rapid assessment and treatment (RAT) in place to support early identification and treatment of acute illness / trauma(13-Dec-2022), RAT area is monitored by a nurse in charge and emergency physician in charge (EPIC) to safety triage patients and initiate any specific tests/ scans or referrals to specialists(13-Dec-2022), Hospital ambulance liaison officer (HALO) in place to support Ambulance off loads.(13-Dec-2022), Daily escalation of pressures in department at site meetings(13-Dec-2022), ED dashboard updated to evidence escalation at site meetings(13-Dec-2022), Escalation to divisional directors for speciality support as requested(13-Dec-2022), Identified nurse to support with complaints in department(13-Dec-2022), Streaming nurse supports with quick rapid assessment and streaming to alternative service accordingly(13-Dec-2022), Standard Operating procedure to support streaming service and expectations of streaming nurse(13-Dec-2022), Streaming nurse to support with quick triage and observations of patients accordingly to ensure high risk patients are diverted accordingly to Majors or prioritised(13-Dec-2022),	Low	Treat	Risk approved at ED CIG and by triumvirate	20-Sep-2022
RSK-411	20-Dec-2022	IF child protection medical assessments continue to be undertaken with current workforce arrangements within the Paediatric Assessment unit (PAU) as part of the current consultant and junior doctor and nursing workload . THEN there will be issues regarding the current workflow and clinical risk within a busy acute/emergency area.	LEADING TO delays and avoidable risk in being able to complete the medical assessments as per RCPCH guidelines and completion of medicolegal child protection reports for multiagency partners and court with the subsequent impact of children suffering further abuse/neglect or death.	Region	Child's Health	Keya Ali	28-Dec-2023	31-Jan-2024	Planned	20	20	10	Junior doctor rota to include allocated slots in the week for child protection medical assessments and report writing (16-Aug-2023), Time for child protection medical assessments to be factored into consultant's job plans with additional consultant on the rota for child protection medical assessments and supervision as per RCPCH standards. (16-Aug-2023), Protected SPA time for Medical Report writing and formal peer review processes. Time for paediatric consultants to meet with junior team and deliver education on interpretation of injuries, multiagency working and child protection processes. (16-Aug-2023), In other areas the service is provided by community paediatricians. Trust to offer service for children under the age of two years only. Further discussions with BLMK ICB to progress this issue (16-Aug-2023), To include child protection activity within the winter escalation policy with a clear process as to how this activity will be managed safely given bed pressures (PAU closed to admissions and children to be seen in PED). (16-Aug-2023), To move location to an outpatient or day care setting ensuring appropriate IT support/ equipment and support staff/ chaperone available.	Clinicians currently try and complete this work within regular workload or work additional hours without remuneration.(20-Dec-2022), Wherever possible the examinations are undertaken during the quieter times to enable an appropriate chaperone is present.(20-Dec-2022), Wherever possible cubicles are used for examinations(20-Dec-2022), The safeguarding nurses try and make themselves available. This has an impact on safeguarding team's capacity.(20-Dec-2022), HIE access on eCare SystmOne on certain computers only.(20-Dec-2022), Social worker requested to attend medical assessment(20-Dec-2022)	Low	Treat	Risk date extended	28-Sep-2022

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-417	13-Jan-2023	IF the Gastroenterology Department has an overwhelming number of new and follow up patients on their waiting list, and there is a significant demand on follow up capacity THEN there may be insufficient capacity to meet the demand on the service and recover the backlog of patients	LEADING TO Patients not being seen in a timely manner, Urgent referrals not being seen as quickly as they should, poor patient experience, competing priorities between new and follow up demand.	Region	Specialty Medicine	Elizabeth Vella	13-Nov-2023	31-Dec-2023	Overdue	20	20	10	Patients Expedited through WLI sessions (02-Oct-2023), Recruitment of 1WTE middle grade. (30-Oct-2023), PTL validation of all patients over 18 weeks (02-Oct-2023), Admin validation of Non-RTT (02-Oct-2023), Recruitment of nursing staff to enable more OPA capacity and implementation of IBD PIFU (06-Nov-2023), Clinical and Admin review of all booked appointments	Triaging of referrals where possible(13-Jan-2023), Slot utilisation report has been created and used by Patient Access and Medicine Division to ensure all slots are fully utilised and not wasted.(13-Jan-2023), Patient Pathway Coordinators ensure results are reviewed and follow up appointments booked when needed- linked to PTL validation.(13-Jan-2023), Clinical Validation of the non-RTT starting with the most overdue patients. This relies on free sessions and is slow progress at 25 patients per session.(13-Jan-2023), PIFU is implemented in Gastro, only small numbers of around 10-15 per month. Clinical triage is increasing numbers being put on PIFU.(13-Jan-2023), Patient Pathway Coordinators are now starting to review some clinics ahead of time to identify any duplicate appointments.(13-Jan-2023), One off report was run identifying over 200 duplicates, all duplicates were removed by Medicine Division.(13-Jan-2023), Recruitment into 12-month consultant and 12 month middle grade post(13-Jan-2023), Service review to allow clinical triage of new and	Low	Treat	Risk reviewed at Specialty Medicine CIG - No changed to risk.	21-Oct-2022
RSK-427	08-Feb-2023	IF there is an increase in demand for inpatient and ED CT scans THEN some scans will be routinely waiting a number of days to be performed.	LEADING TO potential delays to patient treatment; delays to discharge.	Region	Diagnostic & Screening	Michael Pashler	14-Dec-2023	31-Mar-2024	Planned	16	20	6	Purchase and installation of 4th CT scanner (15-Sep-2023), Recruitment of Radiographers (15-Sep-2023)	Recruitment of Imaging Assistants(08-Feb-2023), Patients are prioritised based on clinical urgency to minimise risks as best as possible(09-Feb-2023), Adopting a fluid approach to managing the workload. Adapting to changes in priority at short notice.(09-Feb-2023)	Low	Treat	JD review and planned recruitment. Risk remains high due to staffing pressure and wait times.	20-Oct-2022
RSK-438	07-Mar-2023	IF children and young people <17-years waiting for a mental health bed or a mental health assessment, have an increased length of stay in the Emergency Department THEN the patients may have an increased waiting time; exposure to acute traumatic incidents potentially triggering challenging behaviours; increased pressure on staff	LEADING TO increased risk of self-harm and suicide; increase in complaints; poor patient experience; increased risk of violence/abusive towards staff; staff absence/low morale/stress;	Region	Emergency Department	Kirsty McKenzie-Martin	04-Dec-2023	08-Jan-2024	Pending	15	20	6	Reviewing specialist pathways to support flow within ED department (13-Jul-2023)	Daily escalation of pressures in department at site meetings, (07-Mar-2023), Staff support escalated daily to the Matron of the day at safety huddle(07-Mar-2023), Escalation meetings daily with relevant stakeholders to discuss care and support(07-Mar-2023), CAHMS provide RMN support, if unable escalated at site meeting(07-Mar-2023), Escalation to divisional directors for speciality support as appropriate(07-Mar-2023), ESR training in place to support development of staff(07-Mar-2023), Identified nurse to support with complaints in department(07-Mar-2023), If appropriate and on appropriate risk assessments carried out, patients can use ward 4 or 5 for a shower(07-Mar-2023), Meals provided by cook chill(07-Mar-2023), Families if appropriate encouraged to stay to support patient(07-Mar-2023), In the adult ED Panic button in place in Minors(07-Mar-2023), Body cam worn by staff in high-risk localities such as streaming and triage in the adult ED(07-Mar-	Low	Treat	Risk description simplified following review at Risk & Compliance Board (05/04/23)	08-Nov-2022

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-456	17-May-2023	IF there is an increasing demand on the Blood Sciences service and staffing levels are no longer sufficient to provide a robust 24/7 service THEN staff will be unable to continue to meet service demands	LEADING TO: 1.The inability to cover 24/7 service and several gaps in the rota, which has already been evidenced 4 times in the last 3 months and this will result in no Out of hours cover which will mean the Trust will need to consider closing AE/Maternity and Theatres 2.Chief BMS having to cover shifts and calling people on sickness leave to help cover shifts due to lack of staff 3.An increasing delay in the turnaround time of results – KPI's for Biochemistry are significantly failing to meet the demands of the urgent service 4.Risk of losing limited expertise knowledge from department due to sickness 5.The inability to provide resilience cover for shifts due to having insufficient numbers enough to cover the shifts. 6.Increase in overdue governance and quality tasks 7.More samples are marked 'urgent' as clinicians hear of possible delays which exacerbates the problem. 8.A backlog of samples at the end of the day which is carried over to the following day or beyond which impacts integrity of samples from GP's 9.Senior scientific staff spend more time doing routine bench work to address the increase, compromising laboratory governance issues 10.Increasing levels of stress related sickness and turnover of staff, sickness rate is around 6%	Region	Diagnostic & Screening	Jessica Dixon	22-Dec-2023	19-Jan-2024	Planned	20	20	8	Recruitment of staff (22-Dec-2023), Recruit Haematology bank Bnd 4 resource (22-Dec-2023), Recruit Chemistry bank Bnd 6 resource (22-Dec-2023), Recruit Chemistry Agency Bnd 6 resource (22-Dec-2023), Training & Competency progression new staff, Sickness Monitoring (22-Dec-2023)	Use of Agency, Locum and Bank Staff(17-May-2023), Currently utilising the 8a Chief BMS to cover shifts where possible.(17-May-2023), Prioritisation of urgent work(17-May-2023), Existing staff offered overtime(17-May-2023), Increase WTE staff resource in Chemistry within budget(23-Jun-2023), Recruit Haematology agency Bnd 6 resource(23-Jun-2023)	Low	Treat	Ongoing staff pressures.	02-Mar-2023
RSK-457	22-Jun-2023	If there are insufficient staffing levels (radiographers) THEN there will be reduced capacity in the department resulting in closure of the 3rd CT Scanner	LEADING TO delays to patient diagnosis and treatment, potential missed diagnosis; increased stress / increased sickness and potentially inability to retain staff	Region	Diagnostic & Screening	Michael Pashler	14-Dec-2023	31-Mar-2024	Planned	20	20	6	Recruitment of staff (15-Sep-2023)	Prioritising 2WW patients at the expense of urgent, routine and planned/cancer follow-up patients(27-Jun-2023), Signposting patients to PALS Team, where appropriate(27-Jun-2023)	Low	Treat	JD reviewed and planned recruitment.	22-Jun-2023
RSK-472	04-Aug-2023	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	11-Dec-2023	29-Feb-2024	Planned	25	20	10	Wider roll out of bodycam provision (11-Dec-2023), Widen environmental study to consider patients with mental health, learning disability, dementia etc – holistic approach to care, environment, distraction therapies (18-Dec-2023), 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 (18-Dec-2023), Training for staff in managing patients with mental health, learning disability, dementia etc De -escalation procedure/techniques (18-Dec-2023), Development of an information pocket card for staff (27-Oct-2023), Listening events on the road, staff engagement sessions (11-Dec-2023), Ensure feedback from incidents to staff and lessons learnt shared amongst wider organisation (18-Dec-2023),	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	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
RSK-473	10-Aug-2023	IF the Trust does not have a working CTG flatbed scanner THEN CTGs may not being available on EDM negatively impacting on patient care, the ability to review / audit / investigate / birth reflections	LEADING TO poor patient care / experience; delay in learning & improving from incidents, complaints, claims etc; inability to provide evidence for inquests/claims	Region	Patient Access	Stevie Jones	30-Nov-2023	30-Dec-2023	Overdue	20	20	8	Recruitment of sufficient staff for 2 CTG scanners to be running daily (30-Nov-2023)	Request CTGs from medical records(10-Aug-2023), Obtain a flatbed scanner with a view to increasing to two scanners.(10-Aug-2023)	Low	Treat	Member of staff in post and currently undertaking training.	20-Feb-2023

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-001	06-Sep-2021	IF all known incidents, accidents and near misses are not reported on the Trust's incident reporting system (Radar); THEN the Trust will be unable to robustly investigate all incidents and near-misses within the required timescales;	LEADING TO an inability to learn from incidents, accidents and near-misses, an inability to stop potentially preventable incidents occurring, potential failure to comply with Duty of Candour legislation requiring the Trust to report all known incidents where the severity was moderate or higher, potential under reporting to the Learning from Patient Safety Events (LfPSE) system, and potential failure to meet Trust Key Performance	Organisation		Tina Worth	27-Dec-2023	31-Mar-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	Overall incident reporting rate has shown to be increasing. referenced in governance meetings that certain types of incidents remain lowly reported though.	06-Sep-2021
RSK-035	28-Sep-2021	IF there is a high turnover of staff due to: work pressure, not having the opportunity to work at the top of their licence, lack of capacity for development, lack of capacity for supervision / support. Also difficulty in recruiting. Loss of staff to primary care which offers more attractive working hours. THEN there will be insufficient staff in pharmacy to meet demands of the organisation and ensure patient safety in the use of medicines.	LEADING TO: 1. increased length of stay due to TTO delay 2. increase in prescribing errors not corrected 3. increase in dispensing errors 4. increase in missed doses 5. failure to meet legal requirements for safe and secure use of medicines 6. harm to the patients 7. adverse impact on mental health of Pharmacy staff All resulting in adverse patient outcomes. Lack of financial control on medicines expenditure Breach of CQC regulations	Organisation		Helen Chadwick	01-Dec-2023	31-Jan-2024	Planned	20	16	6	Actively recruiting staff (01-Dec-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	ongoing	07-Aug-2019
RSK-036	28-Sep-2021	If there is no capacity in the Pharmacy Team THEN there is a risk that Pharmacy and Medicines Policies and Procedures may not be reviewed and updated in a timely manner, nor new policies developed	Leading to: Potential for Policies & Procedures to be out of date Potential for staff to follow out of date Policies & Procedures Failure to meet CQC requirements Lack of guidance for staff Potential harm to patients	Organisation		Helen Chadwick	01-Dec-2023	29-Feb-2024	Planned	16	16	6	Recruitment of staff (01-Dec-2023)	Use of remote bank staff to update policies(28-Sep-2021), Business Case for additional Pharmacy staff(19-Apr-2022)	Low	Treat	governance gap analysis in process	01-Oct-2021
RSK-053	01-Oct-2021	IF the old building management system (BMS) does not effectively regulate the temperature within orthopaedic theatres 11 & 12. THEN when the the outside temperature is warm, and the temperature in theatres increases to above 25-26 degrees theatre staff are unable to regulate this from the theatre suite, and estates are also unable to reduce the temperature. **The recommended temperature perform orthopaedic surgery is 19 -20 degrees.	LEADING TO Patients – increases the possibility of infections, performing joint replacements at higher temperatures goes against manufacturers recommendations when using bone cement as the cement sets too quickly. Cancellations in surgery, Staffing - This also has a detrimental impact of staff that could be wearing x-ray gowns and are scrubbed, wearing gowns, gloves & face masks, making the staff and clinicians feel unwell and unable to work.	Region	Anaesthetics & Theatres	Arabelle Casey	07-Dec-2023	04-Jan-2024	Pending	9	16	4	Implementation of surgical block as part of new hospital build, Improved alignment with Estates to investigate issues and make plans to resolve (03-Jun-2023), Plan in place to resolve issues with AHU for 27th-29th December	Estates department are currently investigating. We are unable to put controls into place at this time.(01-Oct-2021)	Low	Treat	NO further update	18-Jun-2021

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RSK-055	01-Oct-2021	IF the staffing within theatres is not made adequate THEN the elective and emergency operating lists will not be covered	LEADING TO not achieving the required target and potentially cancelling patients, which will increase patient waiting times, reduction in income and increased costs to fulfil staffing i.e. Agency and Bank spend	Region	Anaesthetics & Theatres	Arabelle Casey	07-Dec-2023	15-Feb-2024	Planned	12	16	9	Increase establishment to reduce reliance on expensive and temporary measures i.e. Agency and Bank (07-Dec-2023)	This risk is currently being mitigated by the use bank, approx. 80 /100 shifts of varying lengths per week. Agency staff approx. 300 hours per week. Even with the additional support from bank and agency staff we still struggle to provide staff for all sessions, this has recently led to cancelling lists. These risks are exacerbated when staff are off sick or absent for training / annual leave.(01-Oct-2021), GAPS: There are significant gaps in the theatre rota - 19 WTE posts are required to meet latest review of theatre staffing requirements.(01-Oct-2021), Recruited to 8x WTE(27-Apr-2022), Recruited 5x International Nurses(27-Apr-2022), Approval of Business Case for 10x additional members of staff(27-Apr-2022), 10x additional members of staff to be recruited(27-Apr-2022), Recruitment programme is underway(13-Jun-2022)	Medium	Treat	Robust rolling recruitment programme in place 17 x Agency staff in place 14 x International nurses now recruited Workforce Business Case being presented to Execs 10.02.23	24-Jun-2021
RSK-080	15-Oct-2021	IF the pathway unit is not in place THEN moderate to severe head injury patients will not be appropriately cared for and will not be treated in accordance with NICE guidance (CG176: Head injury: assessment and early management, updated September 2019) These patients may frequently fall under the remit of the T&O Team or be nursed on a surgical ward when they should be under a neurological team.	LEADING TO Potential reduction in patient safety - T&O surgeons and nursing teams may be unaware of how to care for patients with moderate to severe head injuries especially patient who are anticoagulated. Clinicians may have to wait for an opinion from the Tertiary Centre staff training, competency and experience Serious incidents Reduced patient experience	Region	Musculoskeletal	Stephen Ngugi	12-Oct-2023	12-Nov-2023	Overdue	12	16	8		- On going discussions with Senior Medical Team - CSU Lead to escalate via trauma network - Alert process is in place for escalation within T&O & externally. - Resources available at tertiary site for advice/support(15-Oct-2021), 1, 2 c& 3. mitigating controls - Policy for management of head injuries has been developed - Awaiting appointment of head injury liaison Nurse - Long term plan for observation block to be built.(15-Oct-2021), GAPS: - Trust is not in line with other trauma units - Regional trauma centre advises head injury should not be managed by trauma and orthopaedics and after 24 hours the patient should be referred to neurosurgery. - Potential delay in opinion from Tertiary Centre(15-Oct-2021), Implementation of Pathway Unit(27-Apr-2022)	Low	Treat	Risks graded 8 or above must be reviewed at least monthly. Therefore Risk Review Due changed to 21st July 2023	14-Jul-2011
RSK-088	15-Oct-2021	IF there is overcrowding and insufficient space in the Neonatal Unit. THEN we will be unable to meet patient needs or network requirements (without the increase in cot numbers and corresponding cot spacing).	LEADING TO potential removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements.	Region	Child's Health	Lazarus Anguvaa	28-Dec-2023	01-Feb-2024	Planned	25	16	9	New Women's & Children's hospital build, Discussions with network to ensure appropriate admission/transfers into unit wherever possible Increase in accommodation added to capital plan (09-Mar-2023), Overcrowding at bedside - ensure prompt removal of equipment when not required. Wall mounted equipment to allow access at cotside Ultimately will not be resolved until new build has been completed and NNU moves across (09-Mar-2023)	1. Reconfiguration of cots to create more space and extra cots and capacity, though this still does not meet PHE or national standards(15-Oct-2021), Business Case for Refurnishing Milk Kitchen and Sluice(15-Oct-2021), 2. Parents asked to leave NNU during interventional procedures, ward rounds etc. Restricted visiting during COVID(15-Oct-2021), 3. Added to capital plan(15-Oct-2021), x1 cubicle has been removed to provide workspace for staff(09-Mar-2023)	Low	Treat	Risk assessment needs rewording and matching the risk reported on the register . This will then need to go through CIG	19-Dec-2022

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RSK-126	04-Nov-2021	IF cot spacing in the Neonatal Unit does not comply with BAPM guidance or the latest PHE guidance for COVID-19 (the Unit is seeking to increase both total cot spacing and cot numbers by 4 HDU/ITU cots in line with Network 5 year projections of acuity and demand, and spacing in line with National Recommendations) THEN there will be overcrowding and insufficient space in the Neonatal Unit, exacerbated by need for social distancing due to COVID-19. The milk kitchen was condemned due to this	LEADING TO an inability to meet patient needs or network requirements. We will now also be unable to meet PHE recommendations for social distancing This may result in a removal of Level 2 status if we continue to have insufficient space to adequately fulfil our Network responsibilities and deliver care in line with national requirements. This may also impact on our ability to protect babies and their families during COVID	Organisation		Lazarus Anguvaa	03-Nov-2023	30-Nov-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-135	04-Nov-2021	IF the Pathology LIMS system is no longer sufficient for the needs of the department, due to being outdated with a limited time remaining on its contract THEN the system is at risk of failure, virus infiltration and being unsupported by the supplier	LEADING TO the Pathology service being halted and contingency plans would have to be implemented. Sensitive information could lost or security of the information could be breached.	Region	Diagnostic & Screening	Rebecca Potter	03-Jan-2024	19-Jan-2024	Planned	16	16	4	UAT to be completed (03-Jan-2024)	Systems manager regularly liaises with Clinysis to rectify IT failures(04-Nov-2021), Meetings with S4 to establish joint procurement take place periodically(04-Nov-2021), Project Manager role identified to lead project for MKUH(04-Nov-2021), High Level Design Completed(01-Dec-2021), Low Level Design to be completed(03-Feb-2022)	Low	Treat	UAT to begin January 24	01-Sep-2019
RSK-142	04-Nov-2021	IF there is insufficient capacity and ongoing unsustainable demand for dietetic input for Paediatric patients (both inpatient and outpatient) . IF Home Enterally Fed Paediatrics patients continue to be seen our outpatient structure which is not adequate to meet their demands and needs. This means that these high risk groups of Children and Young People are not accessing the necessary specialist nutritional support at the appropriate time in their development THEN staff may be unable to cover a service that has not been serviced correctly, and the paediatric team cannot provide a full dietetic service to children and young people in the Milton Keynes area	LEADING TO patient care and patient safety may be at risk, vulnerable children may become nutritionally compromised, the service may be unable to assess and advise new patients and review existing patients in a timely manner, and there may be an impact on patients nutritional status and longer term dietary management on what is a very vulnerable group of patients. The majority of our caseload is infants or tube fed infants and children where there nutrition and growth is a priority.	Organisation		Elizabeth Pryke	05-Dec-2023	05-Jan-2024	Pending	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	Insufficient time to take this forward	01-Nov-2021
RSK-157	12-Nov-2021	IF There is insufficient Speech and Language Therapy capacity to meet referrals demands resulting from poor workforce supply/ capacity and inefficient use of clinical time due to IT access.	LEADING TO patients not receiving input in line with Sentinel Stroke Audit National Programme (SSNAP) (communication and and timely input to support patient discharges Delayed discharges, poor patient experience and increased length of staff	Region	Therapies	Jamie Stamp	18-Dec-2023	16-Jan-2024	Planned	16	16	4	To update SLA for Speech and language Therapy, to update on new template, to reflect current provision and to capture activity date for discussion at quarterly review meetings (18-Dec-2023)	Daily updates are provided by the SLT to confirm outstanding referrals and priority patients for that day.(12-Nov-2021), To review opportunities to skill mix current workforce in light of recruitment challenges. For example, meetings to take place with community services to consider increasing therapy assistant time to improve input on the Stroke Unit.(11-Apr-2022), Team Leader is now in post - to ensure that regular meetings are taking place to look at recruitment and training. Band 3 Therapy Assistant (FTC) interviews are scheduled. SSNAP actions plan has been updated to reflect this.(24-Jun-2022), To create Quality Scheduled to capture data relating to Speech and language Therapy activity for discussing at quarterly meetings with the provider. Head of Therapy has met with the Operational lead for medicine to start initial discussion about what data they want captured from a stroke point of view.(24-Jun-2022), To meet with medicine division to understand areas of improvement needed to achieve the SSNAP data for Speech and language Therapy(14-Dec-2022), Arrange meeting with CNWL to discuss current staffing levels and mitigation(14-Dec-2022)	Medium	Treat	Additional Band 5 staff have been recruited, these staff members will need to complete Dysphagia training. Band 7 Lead for SLT was absent over the last few weeks leading to gaps in skill mix. Continuing to work with current SLT provider to review service specification and to agree staffing required to deliver service. Target has been set for the end of the financial year to have clear specification with agreed activity and workforce.	12-Nov-2021

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RSK-377	30-Aug-2022	IF Microbiology does not have a Quality Management System and is unable to provide quality assurance THEN the department may not able to achieve accreditation for the range of tests performed in the department	LEADING TO potential for patients to receive incorrect results or delays in receiving results, diagnosis and treatment, impact on Trust's reputation, financial penalties, loss of Service User Contracts, loss of ICB commissioning, loss of staff, difficulties recruiting staff, inability to manage incidents, audit, Trust policies and equipment records in a timely manner	Region	Diagnostic & Screening	Jessica Dixon	18-Dec-2023	19-Jan-2024	Planned	16	16	8	Review rota Management (18-Dec-2023), Improve training and competency programme (18-Dec-2023)	Quality Manager and Quality Associate Practitioner in post(30-Aug-2022), Monthly KPI's to monitor progression(30-Aug-2022), Additional support utilising bank staff as required(30-Aug-2022), Quality Management System in place that is robust in 5 other disciplines within Pathology(30-Aug-2022), Additional training for staff in utilising the QMS and understanding(30-Aug-2022), Monthly departmental and clinical meetings to review, communicate and action decisions(30-Aug-2022), EQA and IQC participation(30-Aug-2022), Audit Programme(30-Aug-2022), Training and Competency programme(30-Aug-2022), Mock UKAS inspection(30-Aug-2022), 1-1's with Senior staff to establish training gaps(30-Aug-2022), Increase formal training within departments for all staff to use Q-Pulse as required(30-Aug-2022), Improved clarity of roles and responsibilities(30-Aug-2022), Implement stock management system(30-Aug-2022),	Low	Treat	Support ongoing from Quality Team.	01-Jul-2022
RSK-379	01-Sep-2022	IF there is no Specialist HIV Pharmacist THEN the Trust will not be compliant with standards and guidance, potential inability to identify prescribing errors, lack of support for the Multi-Disciplinary Team, potentially increased operational costs	LEADING TO potential decommissioning of HIV service, Lack of screening of prescriptions by specialist pharmacist resulting in increased medication errors and drug wastage, negative impact on staff wellbeing, staff shortages, and difficulties retaining staff, higher operating costs for the service	Region	Specialty Medicine	Clare Woodward	14-Nov-2023	14-Dec-2023	Overdue	16	16	8	Recruitment of HIV Specialist Pharmacist (06-Jun-2023)	Utilising existing pharmacy staff who can't always meet the needs of the service(01-Sep-2022), Specialist nurses and clinicians supporting where they can(01-Sep-2022)	Low	Treat	Risk reviewed at Specialty Medicine CIG - Oxford Pharmacist assists with MDT's but not with prescriptions. Honorary contract sits under Pharmacy and requires approval	20-May-2022
RSK-399	09-Nov-2022	IF the staffing establishment within the Pharmacy Aseptic Team is not resilient and there is insufficient senior aseptic staff to complete the higher technical tasks THEN there is potential for the department to be regularly working over capacity	LEADING TO a breach in regulatory guidance, an ability to maintain the QMS work required.	Region	Pharmacy	Christopher Woodard	01-Dec-2023	29-Feb-2024	Planned	16	16	12	Review of senior staffing, including succession planning. Develop posts/time for staff to focus purely on quality tasks, not just operational. (31-Oct-2023), work with finance to understand funding streams to enable business case development. (31-Oct-2023), Request QA roles utilising savings made by pharmacy procurement. (31-Oct-2023)	Outsource some patient specific chemotherapy(09-Nov-2022), Discussed at monthly QMS meeting, more critical QMS tasks being prioritised for available time at present(09-Nov-2022), Review of staffing to establish what additional staffing is needed and who to improve retention and development of staff we currently have(09-Nov-2022)	Medium	Treat	Movement of budget to support but still requires resolution	01-Nov-2022
RSK-414	13-Jan-2023	IF The Dermatology Department does not have appropriately trained nursing staff to be able to provide a Phototherapy Service THEN the service will not be able to provide a phototherapy, which is an integral part of the Dermatology Service	LEADING to patients that are unable to access Phototherapiy being placed potentially on medication unnecessarily to try to manage their conditions in the interim	Region	Specialty Medicine	Suzanne Raven	27-Dec-2023	31-Jan-2024	Pending	16	16	12		List is closed to new referrals(13-Jan-2023), Patients have been reviewed and where appropriate placed on medication(13-Jan-2023), Recruitment of adequately trained phototherapy nurse.(13-Jan-2023)	Low	Treat	No update on recruitment - service review meeting planned for 11/1/24 will update following meeting	02-Nov-2022
RSK-481	07-Sep-2023	IF there is no designated vascular access team/service or additional staff are not trained to place PICC and midlines THEN patients will not get PICC /midlines or will wait unacceptable lengths of time for appropriate vascular access to be inserted.	LEADING TO Patients not receiving essential medications/nutrition; Patients having to endure multiple peripheral cannula placements; Patients not having their nutritional requirements met, leading to malnutrition and weight loss as an inpatient. There is only one type of parenteral nutrition available for peripheral access; for most patients this does not meet protein or electrolyte requirements; An increased risk of pressure sores and delayed wound healing due to poor nutrition: Increasing the risk of patients suffering thrombophlebitis from peripheral lines used for infusions with high osmolarity (PN); Increased risk of arm DVTs from multiple cannulations; Extended length of stay due to delayed treatment and the above; Undue pain and suffering for the patient; Poor patient experience; The potential for clinical negligence/litigation/complaints; Patients needing to go to theatre for central line insertions, which is more distressing for the patient and less cost effective.	Region	Specialty Medicine	Jane Radice	08-Dec-2023	14-Dec-2023	Overdue	20	16	4	Ability for Vascular Access Service to place inpatient PICC lines and inpatient midlines, Implementation of a repair service for patients presenting to ED with fractured tunnelled lines, Vascular Access Service to provide support/intervention for inpatients with line occlusions. i.e to give alteplase, Training for all staff managing patients with all types of central lines, Vascular Access Service to monitor/audit inpatient central lines	Peripheral cannulas are placed. But this limits the parenteral nutrition that can be given. There is only one type of peripheral Parenteral nutrition available and for most patients this does not meet protein and electrolyte requirements.(07-Sep-2023), Peripheral cannula are changed every 48hrs due to the high osmolarity of PN(07-Sep-2023), ICU staff are frequently required to assist with cannulation of these patients(07-Sep-2023), When no peripheral access can be obtained, patients have been booked into theatre for a central line. This is a short-term central line that requires removal after 14 days. A PICC line can remain in place for 1 year(07-Sep-2023)	Low	Treat	Risk approved at Specialty Medicine CIG	08-Aug-2023

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RSK-482	07-Sep-2023	IF patients are not able to have a PICC line for parenteral nutrition, addaven and cernevit THEN patients will require multiple peripheral cannulas.	LEADING TO patient harm (the risk of thrombophlebitis and DVT) and the potential for litigation and patient complaints.	Region	Specialty Medicine	Jane Radice	20-Nov-2023	17-Jan-2024	Planned	20	16	4	Ability for Vascular Access Service to place inpatient PICC lines and inpatient midlines, Implementation of a repair service for patients presenting to ED with fractured tunnelled lines, Vascular Access Service to provide support/intervention for inpatients with line occlusions. i.e to give alteplase, Training for all staff managing patients with all types of central lines, Vascular Access Service to monitor/audit inpatient central lines	1.Peripheral cannulas are placed. But this limits the parenteral nutrition that can be given. There is only one type of peripheral Parenteral nutrition available and for most patients this does not meet protein and electrolyte requirements(07-Sep-2023), Peripheral cannula requires changing every 48hrs due to the high osmolarity of PN(07-Sep-2023), ICU staff are frequently required to assist with cannulation of these patients(07-Sep-2023), When no peripheral access can be obtained, patients have been booked into theatre for a central line. This is a short-term central line that requires removal after 14 days. A PICC line can remain in place for 1 year(07-Sep-2023)	Low	Treat	Risk approved at Specialty CIG meeting	08-Aug-2023
RSK-483	07-Sep-2023	IF there is no designated vascular access team/service with the skill to repair tunnelled catheters THEN patients are admitted to MKUH, and the line is removed and reinserted or they require transfer to St. Marks or OUH for their line team to repair the line. Two patients with Home PN have required transferring to St. Marks for this reason	LEADING TO poor patient experience/ patient requiring admission for replacement/increased costs; Inadequate number of HCPs trained to place PICC and midlines at MKUH. Inpatients requiring PICC lines have waited up to two weeks for the line to be inserted and some have not received a line at all; There is no inpatient vascular access team at MKUH. Patients are referred to interventional radiology. There is significantly reduced capacity within the IR department to perform routine, urgent 2ww and emergency procedures for both inpatients and outpatients. There are two doctors trained to place PICC lines for all inpatients. There is one nurse in IR currently being trained; Patients receiving parenteral nutrition require PICC lines	Region	Specialty Medicine	Jane Radice	20-Nov-2023	17-Jan-2024	Planned	20	16	4	Ability for Vascular Access Service to place inpatient PICC lines and inpatient midlines, Implementation of a repair service for patients presenting to ED with fractured tunnelled lines, Vascular Access Service to provide support/intervention for inpatients with line occlusions. i.e to give alteplase, Training for all staff managing patients with all types of central lines, Vascular Access Service to monitor/audit inpatient central lines	Peripheral cannulas are placed. But this limits the parenteral nutrition that can be given. There is only one type of peripheral Parenteral nutrition available and for most patients this does not meet protein and electrolyte requirements.(07-Sep-2023), Peripheral cannula requires changing every 48hrs due to the high osmolarity of PN(07-Sep-2023), ICU staff are frequently required to assist with cannulation of these patients(07-Sep-2023), When no peripheral access can be obtained, patients have been booked into theatre for a central line. This is a short-term central line that requires removal after 14 days. A PICC line can remain in place for 1 year(07-Sep-2023)	Low	Treat	Risk approved at Specialty Medicine CIG	08-Aug-2023
RSK-490	28-Sep-2023	IF there is the absence of a competent person to deliver Manual handling and Ergonomic DSE compliance THEN the Trust will be unable to provide training, advice and guidance to staff in relation to manual handling and ergonomics	LEADING TO staff, patients and visitors are at increased of injury, ill health including musculoskeletal injury, sprains, strains, stress – increased sickness absence, low staff morale; Pressure sore development where appropriate equipment is not available and patient is left on floor for a period of time e.g. beds, equipment to manage the fallen patient; Patient experience compromised along with privacy and dignity; Trust at risk of increased staff absence, patient complaints, adverse publicity in local press, claims/litigation and financial costs of settlements; Trust at risk of enforcement action from the Health & Safety Executive Inspectorate for not providing a safe place of work and complying with legislation – verbal advice, improvement/prohibition notices, criminal prosecution, fee for intervention from investigation enquiries	Region	Workforce	Louise Clayton	24-Nov-2023	31-Dec-2023	Overdue	16	16	4	Recruit temporary cover through agency (03-Jan-2024), Recruit to substantive post (03-Jan-2024)	Use of external provider to supply training(28-Sep-2023)	Low	Treat		17-Sep-2023
RSK-492	25-Oct-2023	IF the Corneal Topographer is not networked to the MKUH internet THEN the machine cannot receive updates, the machine cannot be serviced and the patient information cannot be backed up.	LEADING TO increased risk of malfunction, inability to scan patients; inability to monitor patients; delayed diagnosis and treatment; the machine does not have the most up to date software; potential loss of patient information; increased complaints and litigation; inability to comply with NHS DSPT Standards; vulnerability to cyber attacks	Region	Head & Neck	Louise James	05-Dec-2023	05-Jan-2024	Pending	16	16	6	Corneal Tomography Machine to be networked (05-Dec-2023)	Machine is switched on prior to scanning a patient, then switched off straight after use(25-Oct-2023), Individual user login added to the PC. Machine is used by 8 staff members, all with their own username and password(25-Oct-2023)	Low	Treat	No update to networking this machine as of 5/12/23.	26-Jul-2023
RSK-500	15-Nov-2023	IF the capacity to increase Consultant-led Sleep New appointments is not increased THEN patients will face significant delays in appointment waiting times	LEADING TO DM01 breaches and potentially patient safety	Region	Internal Medicine	Alexandra Peers	15-Nov-2023	27-Nov-2023	Overdue	16	16	4	Demand and Capacity Review (11-Dec-2023)	Operations Team are providing adhoc additional capacity(15-Nov-2023), All referrals are triaged by Chief Respiratory Physiologist(15-Nov-2023), Respiratory Physiology Pathway Administrator reviewing weekly(15-Nov-2023), Operations Respiratory Physiology Pathway Administrator reviewing weekly(15-Nov-2023), Urgent patients prioritised(15-Nov-2023), Change in pathway to allow Chief Respiratory Physiologist to triage patients for Nox(15-Nov-2023), Extremely urgent cases are referred to the weekly Sleep MDT(15-Nov-2023)	Low	Treat	Risk approved at Internal Medicine CIG Meeting 27/10/23	18-Oct-2023

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-019	22-Sep-2021	IF there is an increased number of incidents of violence and aggression in Emergency Department THEN there will be an impact on patient safety, staff mental and physical health	LEADING TO an increased risk of physical or verbal damage to staff or other patients, risk of delay in care whilst incidents resolved; potential for litigation or claims dependent on harm; Increased staff sickness rate, poor retention and recruitment of staff; negative impact on Trust reputation; poor patient experience	Region	Emergency Department	Sushant Tiwari	15-Jun-2023	10-Dec-2023	Overdue	12	15	8	Police panic button in reception and majors, unacceptable behaviour posters + national abuse posters (15-Jun-2023), Security forum for Trust (22-Sep-2021), Review of Reception (15-Jun-2023)	CCTV cameras in place (dead spot remains in "Streaming")(22-Sep-2021), Conflict Resolution training(22-Sep-2021), Incidents reviewed on Datix incident reporting system(22-Sep-2021)	Low	Treat	Risk reviewed by Risk Owner. This is an ongoing risk within the department. No change to risk	09-Mar-2009
RSK-061	07-Oct-2021	IF Audiology staff have to manually input patient data into Auditbase (the Patient Management System for Audiology Services) as there is no link with e- care THEN there is risk of incomplete and inaccurate patient details on the Auditbase system.	LEADING TO the potential for deceased patients being contacted for appointments. Appointment letters may be sent to incorrect addresses and therefore missed appointments Increased temporary and duplicate patient numbers on Auditbase Possible breaching as clinical time is being used for entering patient demographics Clinical governance breaches due to incorrect patient information Loss of income Adverse publicity Adverse effect on morale of all Audiology staff	Region	Head & Neck	Jane Grant	23-Nov-2023	30-Nov-2023	Overdue	12	15	4	Implementation of Auditbase e-care integration	A working group is being set up with H&N to address issues within the service.(07-Oct-2021), The Auditbase upgrade had now taken place and is functioning well. - It is expected that Audiology will start diaglogue with IT to undertake work relating to the link could commence. - Ensuring datix incidents related to this risk are logged and acted upon. - Manual data input is a consequence of the failure of the PAS interface. - Not accepting medical students in Audiology - CEO advised of this in email 15.7.19 from Head of Audiology Services.(07-Oct-2021), IT Request form submitted (24.4.2022) for the development with Auditdata of an interface between Auditbase and e-care: 1. To enable demographics to be downloaded from e- care onto Auditbase when a new patient is registered on Auditbase 2. To automatically update demographics on Auditbase when there are changes to demographics on e-care 3. To download results of hearing tests from Auditbase into a results section within e-care(07-Oct-2021), Audiology staff have to manually input patient data into Auditbase(27-Apr-2022),	Low	Treat	Operational manager review plan to address to address risk with service w/c 27/11/23	20-Nov-2017
RSK-101	25-Oct-2021	IF the maternity service at MKUK do not have their own dedicated set of theatres. THEN maternity are left vulnerable to not having a guaranteed emergency theatre available 24hrs a day.	LEADING TO increased risk of poor outcome for mothers and babies if theatre delay; Psychological trauma for staff dealing with potentially avoidable poor outcome; Financial implication to the trust	Region	Women's Health	Melissa Davis	13-Dec-2023	31-Jan-2024	Planned	15	15	6	Hospital new build to include Maternity theatres	Escalation policy available for staff to use in situations where a 2nd theatre is needed by can not be opened(27-Apr-2022), Elective Caesarean work is completed the Theatre 1 during a booked morning session, Theatre 3 is set for obstetric emergencies.(01-Sep-2022), SOP developed to support in the incidence where two theatres are required(13-Apr-2023)	Low	Treat	No change to risk.	06-Sep-2021
RSK-111	26-Oct-2021	IF there is a national shortage of midwives THEN there may be insufficient midwives to provide for the needs of MKUH patients	LEADING TO a local negative impact on delivering excellent patient care, patient experience and staff experience.	Region	Women's Health	Katie Selby	13-Dec-2023	31-Jan-2024	Pending	16	15	6	Implement Ockenden 2 (Recalculated headroom/gap) (19-Jul-2023), MSW project (19-Jul-2023)	There are significant efforts to recruit new midwives.(26-Oct-2021), The early recognition by GOLD and the Chief Executive to advertise for new midwives following the Ockenden report.(26-Oct-2021), Also working with NMC to achieve PIN numbers early for newly qualified staff.(26-Oct-2021), Enhanced bank rates.(26-Oct-2021), Rolling job advert for band 5/6 clinical midwives(27-Apr-2022), Review establishment birth rate+ report(27-Apr-2022), Business case for future funding of birth rate+ to be developed.(13-Dec-2022), Business case to be taken to board for agreement.(13-Dec-2022), Workforce retention and recruitment plan(13-Jan-2023), Midwifery workforce plan(13-Jan-2023), Interview and offer shortened MW course places(13-Jan-2023)	Low	Treat	No change to risk.	13-Dec-2022

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-158	12-Nov-2021	IF the escalation beds are open across the medical and surgical divisions. Then the additional patients that will need to be seen will put additional demand on the Inpatient Therapy & Dietetic Services that are already stretched due to long term vacancies.	LEADING TO: Patients deconditioning, nutritional needs of patients may not be met 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	22-Dec-2023	22-Jan-2024	Planned	16	15	6	agency physiotherapist and occupational therapist to cover additional workload. (13-Dec-2023), inpatient improvement project- aiming to review patient pathways to optimise staffing (01-Dec-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)	Low	Treat	Escalation bed numbers remain >60 with one occasion of ward 2b re-opening, locum requests submitted for cover of ward 2b as have been notified that ward 2b is likely to be a surge ward in January.	27-Nov-2018
RSK-159	12-Nov-2021	Patients referred to the Occupational Therapy and Physiotherapy inpatient services covering medical and surgical wards are not being seen in a timely manner due to the number of long term vacancies and national challenges to recruit to vacant posts. THEN there will be a delay in these patients being assessed, treated and discharged.	LEADING TO deconditioning of vulnerable/complex patients requiring a short period of therapy; increased length of stay; potential readmission, increased demand for packages of care requiring double handed provision. patient experience and long term quality of life will also be impacted as patients are being discharged as more dependent on care.	Organisation		Adam Baddeley	19-Dec-2023	31-Jan-2024	Planned	20	15	3	inpatient improvement programme- to ensure optimal staffing and allocation (01-Dec-2023)	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),	Low	Treat	Sickness levels have increased, delays in bank and agency approval affecting ability to cover gaps, vacancies remain above 10 WTE.	04-Mar-2019
RSK-166	12-Nov-2021	IF there is an increasing workload and a lack of Consultant Pathologists THEN there is a risk that the Cellular Pathology department will be unable to meet the clinical needs of the service	LEADING TO potential inability to meet cancer reporting targets; potential to miss an unexpected malignancy; reporting backlog may also increase	Region	Diagnostic & Screening	Angus Molyneux	18-Dec-2023	19-Jan-2024	Planned	15	15	3	Recruitment (18-Dec-2023)	Outsourcing non-urgent work(12-Nov-2021), Additional hours worked - in house Pathologists(12-Nov-2021), Locum Pathologist in place working limited hours(12-Nov-2021), Prioritising 2 week wait reports(12-Nov-2021), Prioritising urgent reports(12-Nov-2021), Prioritising work based on clinical information(12-Nov-2021), Appoint to substantive Consultant post and LAS post(12-Nov-2021), Purchase additional Microscope for 8th Consultant(11-May-2022), 8th Consultant start date and induction to be completed.(11-May-2022)	Low	Treat	Increased risk discussed at PQHS and PCOM December 23.	01-Jun-2022

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-170	12-Nov-2021	IF the Autoclave machines are not replaced THEN there is a risk that the Pathology department will be unable to sterilise bio-hazardous laboratory waste prior to discarding. Accumulation of waste potentially infective, bad odour, and consuming much needed space. External contractors can remove category 1 and 2 waste only, category 3 waste cannot be removed from the site without being processed through the autoclave.	LEADING TO Health & safety risk to the laboratory staff; Failure to meet COSHH regulations in relation to waste management and autoclave of all HG3 known and suspected biological agents/clinical materials waste; potential disruption to the service; potential to affect Trust's reputation; accumulation of waste products; limiting user of autoclave to preserve lifespan	Region	Diagnostic & Screening	Rebecca Potter	18-Dec-2023	19-Jan-2024	Planned	12	15	5	Ensure robust Autoclave contingency plan to deploy contractors to collect and manage hazardous waste is tried and tested (18-Dec-2023)	PPE; Gloves, safety goggles, ear defenders and Lab coat worn at all times, with good hand hygiene practice. Heavy duty gloves, full face visor and apron must be worn when unloading.(12-Nov-2021), Health & Safety training and competency procedures for all staff working with HG3 waste and the autoclaves.(12-Nov-2021), The autoclave maintenance is performed once per week to regularly check working order and functionality.(12-Nov-2021), Business Case Development for replacement/repair of autoclaves(11-May-2022), Autoclave thermometric tests and calibrations to ensure correct processing of load. Checking printout of every run to ensure process passed. Only authorised staff to work on autoclaves.(12-Sep-2022), 2nd autoclave being used to supply spares – these will run out(12-Sep-2022), Report deficiencies to Estates. Report incidents onto RADAR and escalate to senior management team(12-Sep-2022), Waste is being segregated in to two waste streams	Low	Treat	Supply has been awarded to Wolflabs, expected onsite Feb 24.	10-Jul-2022
RSK-176	12-Nov-2021	IF the Cellular Pathology workload continues to increase without sufficient staffing resources this will THEN there is a risk that the department results turnaround time will continue to increase and staffing burnout will occur	LEADING TO further increased turnaround times for processing and reporting specimens for routine and urgent work where a backlog risk has already been identified. This will have a detrimental effect on the patient experience as the potential for missed or delayed diagnosis increases along with stress and wellbeing concerns of the staff.	Region	Diagnostic & Screening	Amanda Brice	18-Dec-2023	19-Jan-2024	Pending	9	15	12	Review of staffing levels and initiation of consultation to extend working hours to include weekends (18-Dec-2023)	Cellular Pathology staff currently work during weekdays and routine cover for weekends is not in place. Weekend cover can be provided by existing staff on a limited and voluntary basis and this impacts on the number of staff available during core hours. The existing work backlog may increase and further work will need to be sent away incurring additional costs(12-Nov-2021), New contract provider for additional dermatology clinics - no change yet to weekend working requirement.(12-Nov-2021)	Low	Treat	Additional patient lists impacting workload, increasing backlog, staff sickness. Insufficient staffing levels to manage increased complexity and activity.	01-May-2021
RSK-250	26-Nov-2021	IF staff across MKUH continue to use eCARE in the same way, that the volumes of requests made to the IT Department remain at their current rate, and the volume of change and project work continues at the current volume THEN the IT Department will become less responsive and a range of functions within eCARE will continue to be left without action	LEADING TO increased clinical risk, increased risk to performance of eCARE, potential disruption to staff, and delays in the deliver or projects and realising their benefits	Organisation		Craig York	29-Nov-2023	01-Mar-2024	Planned	15	15	3	Identification of staff time and resources (11-Apr-2023), Business case being written by the end of spring 2023 to identify the amount of staff time required. Update Aug 2023 - being reconsidered during early stages of DQ review., Review volumes against historical figures to reflect reality of challenge. Include in business case. Consider additional posts for all.	Prioritisation of workload is in place to cover the most impacting of issues or projects, however this only reduces the potential impact slightly(26-Nov-2021)	Low	Treat	Volume of work is increasing month on month without additional staff to support.	25-Jan-2023
RSK-271	30-Nov-2021	IF there is insufficient space within the Medical Equipment Library (MEL) THEN MEL staff will be unable to carry out the required cleaning process to comply with the appropriate guidelines set by CQC and MHRA	LEADING TO Lack of cleaning and processing space due to the growth of the MEL over the years means not keeping unprocessed and processed equipment separately, not complying with CQC Regulation 15: Premises and equipment and MHRA Documentation: Managing Medical Devices January 2021	Region	Estates	Ayca Ahmed	18-Dec-2023	18-Jan-2024	Planned	15	15	3	The MEL dept relocation is on the draft capital plan under estates (18-Dec-2023)	Staff members are taking processed equipment straight to the shelving areas as soon as it is cleaned to avoid cross contamination. This ensure equipment is kept separate, but this is not a productive method of working(30-Nov-2021), Issue has been raised at Space Committee (June 2021)(30-Nov-2021), 2019-2020 Additional office has been provided, outside of the main department for the Service Manager and the Equipment training Auditor. This has created some additional space for the Library(30-Nov-2021), 2019-2020 Additional storage provided outside of main department in the location of a storage facility within a staircase approved and provided for a number of services under an approved Business Case on the Capital Programme(30-Nov-2021)	Medium	Treat	Reviewed by Medical Devices Manager, no change to risk rating.	23-Aug-2020

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-324	09-Feb-2022	IF there are significant nursing vacancies within the Paediatric Unit, including Maternity Leave and Long-Term Sickness - we are currently 29% of permanent staff roles unfilled- this is being partially mitigated with use of regular Agency and Bank staff THEN there will not be sufficient/safe numbers of nursing staff to cover shifts.	LEADING TO an increased risk for children's safety due to the absence of permanent skilled staff; an increased use of agency; an increasing number of shifts that do not comply with national recommended safe staffing levels	Region	Child's Health	Charlie Nunn	28-Dec-2023	31-Jan-2024	Planned	15	15	9	Establishment Review to be completed (27-Dec-2023)	We are using regular Paediatric Agency and Bank staff to fill gaps wherever possible, we are planning a minimum of 50% of permanent staff on each shift. We are constantly advertising and interviewing for replacement staff- we are steadily recruiting. We are effectively managing Long term sickness in accordance with Trust guidance and with the input of HR(09-Feb-2022)	Low	Treat	Risk assessment in progress ,use of agency and longline agreed until the end of January until fully established	19-Dec-2022
RSK-343	23-May-2022	If there is insufficient dietetic staff in post THEN the service may be unable to meet referrals demand	Leading to patients not receiving dietetic input as needed, which could result in: - Insufficient dietetic education for adults with complex nutritional issues, including adults with diabetes, gastrointestinal disease, those either malnourished or at risk of malnutrition needing nutritional support etc. - Reduction in patient experience and poorer outcomes - MDT will not work effectively as insufficient dietetic input, increasing workload of other members of MDT - Patients with long term conditions such as Diabetes, CHD etc will not have the support to develop the skills for independence and self-management to achieve good health outcomes	Region	Therapies	Elizabeth Pryke	19-Dec-2023	19-Jan-2024	Planned	15	15	9		Triaging patient referrals based on clinical need Daily team huddle to try and manage this and ensure communication is good across the team Advised ward staff so they can start first line nutritional support(23-May-2022), Setting up weekend telephone clinic(23-May-2022), Patients triaged as more urgent will be seen - reduced service communicated to senior nurses, consultants etc(14-Jun-2022), Patients triaged as more urgent will be seen - reduced service communicated to senior nurses, consultants etc(14-Jun-2022), Locum started to provide x 2 clinics / week(29-Jun-2022), Locum Dietitian working remotely To go back out to advert for B6 Dietitian(05-Feb-2023), Recruit Band 6 Dietitian(09-May-2023)	Low	Treat	Fully staffed, however escalation beds open and increased referral rate. Have put in for additional funds linked to winter pressures.	02-May-2022
RSK-388	17-Oct-2022	IF Audiology Services do not get a second testing room equipped for the testing of younger and complex children. This area must be accessible for wide wheelchairs THEN there will be a delay in offering appointments to these children	LEADING TO delayed diagnosis, delayed treatment, delayed management and diagnostic breaches.	Region	Head & Neck	Jane Grant	22-Sep-2023	22-Oct-2023	Overdue	15	15	4	Second testing room equipped for the testing of younger and complex children	Current room being used to full capacity.(17-Oct-2022), Contact Estates and external company to explore options for conversion of workshop on Level 4 to testing facility(17-Oct-2022)	Low	Treat	Claire McGillycuddy has emailed (21.9.23)George Belgrove and asked him to ensure this is fed into the capital round for next year	22-Sep-2022
RSK-406	09-Dec-2022	IF there is a global shortage of electronic components THEN this can impact the lead times for delivery of medical equipment	LEADING TO to inability to replace/repair aged equipment used to monitor and support patients during their hospital care.	Organisation		Ayca Ahmed	18-Dec-2023	18-Jan-2024	Planned	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	20-Jan-2023	Ongoing shortages of medicines with minimal notice or little warning	Possibility of cancellation of patient appointments/operations or a delay to treatment/discharge. Increased cost to the trust in sourcing medicines off of contract prices, courier charges, staff time	Organisation		Nicholas Beason	01-Dec-2023	31-Jan-2024	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	significant shortages continue	27-Nov-2022

Reference	Created on	Description	Impact of risk	Scope	Region	Owner	Last review	Next review	Status	Original score	Current score	Target score	Controls outstanding	Controls implemented	Risk appetite	Risk response	Latest review comment	Risk identified on
RSK-450	18-Apr-2023	IF the Trust cannot scan CTG traces into services user records within 1 month THEN there is a risk CTG's are not available on EDM for review if the patient presents to any maternity area and/or, CTG traces are unavailable on EDM for case review/audit/investigation/ birth reflections/ evidence/ inquest/legal and/or, CTG traces are not stored in a logical order such as Date of Birth or surname alphabetical order and/or, A loss of records	LEADING TO Service user information not being available at the time care is being provided and/or, Learning/ improvement/ complaints/ financial/legal/ reputational impacts	Region	Women's Health	Katie Selby	13-Dec-2023	31-Jan-2024	Planned	15	15	6	Reduce backlog of CTGs that require scanning onto EDM (30-Nov-2023), Implement Fetalink	Flat bed scanners (2) ordered(18-Apr-2023), Increase staffing capacity to close backlog of CTGs to be scanned into EDM(18-Apr-2023), Request CTGs from medical records(03-May-2023), Purchase and implementation of a flatbed scanner with a view to increasing to two scanners(03-May-2023)	Medium	Treat	No change to risk.	11-Apr-2023
RSK-459	27-Jun-2023	IF there is insufficient capacity to maintain a core team of trained radiographers THEN there will be a decreasing number of trained CT staff within the department.	LEADING TO a potential inability to provide a 24-7 emergency CT service	Region	Diagnostic & Screening	Michael Pashler	14-Dec-2023	31-Mar-2024	Planned	15	15	4	Recruit substantive staff to increase capacity for training (15-Sep-2023)	Offering fast-track training to allow staff to volunteer for extra duties to facilitate training(28-Jun-2023), Employ agency staff to cover substantive staff(28-Jun-2023)	Low	Treat	JD review and planned recruitment. Staffing pressures ongoing due to sickness and annual leave.	27-Jun-2023
RSK-467	19-Jul-2023	IF the MOH review group is not MDT quorate THEN the review group will not have an MDT learning focus	LEADING TO missed opportunities to identify learning and implement improvements	Region	Women's Health	Erum Khan	13-Dec-2023	31-Jan-2024	Planned	15	15	6		LW lead to attend MOH meeting if not available MOH meeting time to be changed to suit availability of consultants with risk/radar in job plan(19-Jul-2023)	Low	Treat	No change to risk.	19-Jul-2023

Milton Keynes University Hospital NHS Foundation Trust

Meeting Title	Trust Board	**Date: January 2024**
Report Title	Board Assurance Framework	**Agenda Item Number: 17**
Lead Director	Kate Jarman, Chief of Corporate Services	
Report Author		

Introduction	Assurance Report		
Key Messages to Note	• The Board is asked to review the risk report and note the ongoing work to update the Board Assurance Framework following the Board risk seminar in December 2023		
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	Workforce and Development Assurance Committee, November 2023 Finance and Investment Committee, November 2023 Quality and Clinical Risk Committee, December 2023
Next Steps	N/A
Appendices/Attachments	Board Assurance Framework

Board Risk Seminar Outputs

The Board held a risk seminar in December 2023 to review risks against the delivery of the Trust's strategic objectives. Board members discussed risks in two groups, considering short-term risks (risks with the potential to materialise in the next six months); and long term risks (risks with the potential to materialise in the next three years).

The following risks were documented:

Next six months

- Continued industrial action resulting in significant disruption to service/ care provision
- Change in national financial regime
- Patient harm (increasing emergency demand over winter)
- Inability to discharge patients to appropriate care settings
- System inability to provide adequate social care and mental health capacity
- Political instability and change

Next three years

- Conflicting priorities between ICS and providers
- Lack of availability of skilled staff
- Increasing turnover
- Lack of time to plan and implement long-term transformational change
- Long-term financial arrangements for the NHS
- Growing/ageing population
- Data/ cyber security
- A pandemic

The BAF will be updated to reflect these risks and the updated document (and new risk report) will be presented to the Board seminar in February prior to public Board in March.

Ongoing Risk Programme: Actions and Delivery Timeframes

Action	Delivery Timeframe	Responsible Officers
Risk management development work – including a revised risk report to Board	March 2024 (first draft to February 2024 seminar)	Chief Corporate Services Officer, Trust Secretary and Risk Manager
BAF covering report on risk environment and risk profile	March 2024 (first draft to February 2024 seminar)	Chief Corporate Services Officer, Trust Secretary and Risk Manager
Board seminar on risk	December 2023	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.

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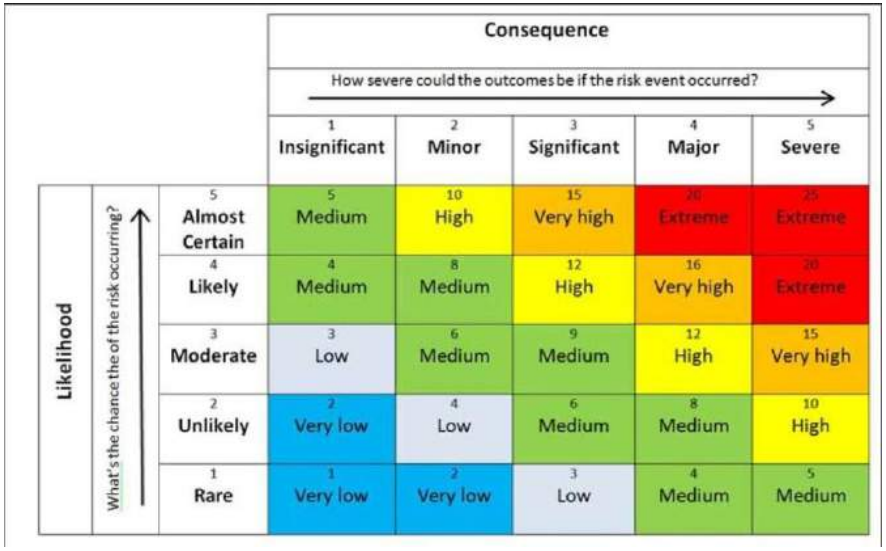
Risk treatment strategy: Terminate, treat, tolerate, transfer

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:

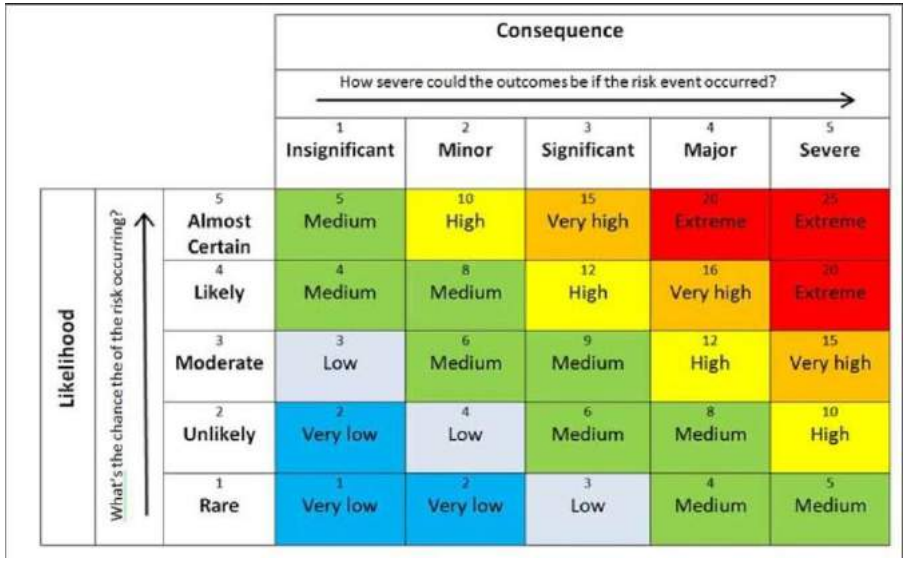


Six to 12 Month Risk Profile (2023)

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

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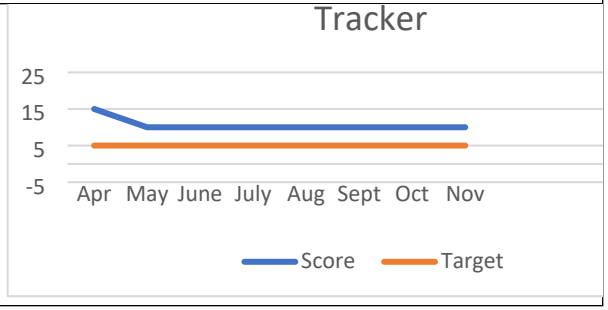
Strategic Risk	If staffing levels are insufficient in one or more ward or department, then patient care may be compromised, leading to an increased risk of harm					
Lead Committee	Workforce	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm
Executive Lead	Chief People Officer	**Consequence**	5	5	**Risk Appetite**	Avoid
Date of Assessment	December 2022	**Likelihood**	2	1	**Risk Treatment Strategy**	Treat
Date of Review	02/11/2023	**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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Strategic Risk	If emergency or elective care pathways are delayed, then patients will wait longer to access treatment, leading to potential risk of harm						
Lead Committee	Quality & Clinical Risk, TEC	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	**Trend: INCREASING**
Executive Lead	Chief Operating Officer	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	Monthly	**Risk Rating**	20	10	**Assurance Rating**		

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

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

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

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

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

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Strategic Risk	If there is overwhelming demand for emergency care on successive days, then patients will not receive timely care, leading to the potential for harm						
Lead Committee	Quality & Clinical Risk Committee	**Risk Rating**	**Current**	**Target**	**Risk Type**	Patient harm	**Trend: INCREASING**
Executive Lead	Chief Operating Officer	**Consequence**	5	5	**Risk Appetite**	Avoid	
Date of Assessment	December 2022	**Likelihood**	4	2	**Risk Treatment Strategy**	Treat	
Date of Review	Monthly	**Risk Rating**	20	10	**Assurance Rating**		

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

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

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

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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	20/11/23	**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

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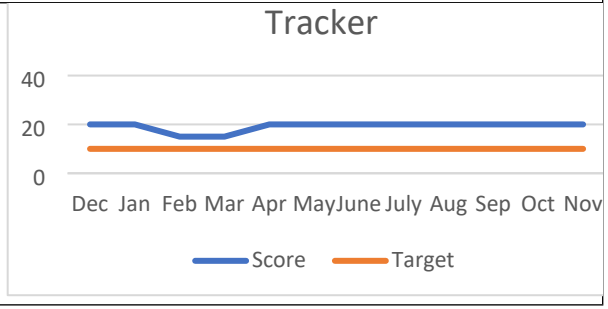
Strategic Risk	If the pathway for patients requiring head and neck cancer services is not improved, then users of MKUH services will continue to face disjointed care, leading to unacceptably long delays for treatment and the risk of poor clinical outcomes					
Lead Committee	Quality & Clinical Risk	**Risk 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	20/11/2023	**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.

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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	20/11/23	**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 the context of the evolving 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. National NHS/E re-forecasting process in relation to additional system funding in November 2023	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 2024/25 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:**	

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
	Equality, Diversity & inclusion (ED&I) Update
	CNST Maternity Incentive Scheme and Board Assurance Framework Sign Off
	Progress update – 2023/24 Quality Priorities
March	Freedom to Speak Up Guardian Report
	Green Plan Update
May	Declaration of Interests Report
	Maternity Patient Survey 2023 interim report
	Freedom to Speak Up Report
	Annual Claims Report
July	Equality, Diversity & inclusion (ED&I) Update
	Falls Annual Report
	Pressure Ulcers Annual Report
September	Green Plan Update (C/F from July 2023)
November	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
	Antimicrobial Stewardship - Annual Report
	Infection Prevention and Control Annual Report