Bundle Trust Board Meeting in Public 5 September 2024

1.1 10:00 - Agenda
0 Agenda Board Meeting in Public - 05.09.24

1.2 10:00 - Apologies
Chair
Item 1 Placeholder Apologies

2 10:01 - Declarations of Interest
Chair
Item 2 Placeholder Declarations of Interest

3 10:02 - Patient Story
Chief Nursing Officer
Item 3 Placeholder Patient Story

4 10:22 - Minutes of the Last Meeting
Chair
Item 4 Minutes Trust Board Meeting in Public 04.07.24 HT

5 10:24 - Matters Arising and Action Log
Chair
Item 5 Board Action Log 04.07.24

6 10:26 - Chair's report
Chair
Item 6 Placeholder Chair’s Report

7 10:31 - Chief Executive's Report
Chief Executive
Item 7 Placeholder Chief Executive’s Report
Item 7a BLMK ICB MKUH 5 September 2024

8 10:41 - Patient Safety Update
Chief Medical Officer/Chief Corporate Services Officer
Item 8 PSIRF Update TB Aug 2024 final

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

10 11:01 - Performance Report
Chief Operating Officer
Item 10 2024-25 Executive Summary M4 Coversheet
Item 10.1 2024-25 Executive Summary M4
Item 10.2 2024-25 Board Scorecard M04
Item 10.3 M04 Board Performance Report - Objective O

Item 10.4 M04 Board Performance Report - Objective 1
Item 10.5 M04 Board Performance Report - Objective 2
Item 10.6 M04 Board Performance Report - Objective 3
Item 10.7 M04 Board Performance Report - Objective 4
Item 10.8 M04 Board Performance Report - Objective 5
Item 10.9 M04 Board Performance Report - Objective 7
Item 10.10 M04 Board Performance Report - Objective 8

11 11:16 - Finance Report
Chief Finance Officer
Item 11 Public Finance Report Month 4 - FINAL

12 11:26 - Workforce Report
Chief People Officer
Item 12 Workforce Report M4 Sept BOARD

13 11:36 - New Hospital Project Update
Deputy Chief Executive
Item 13 Placeholder New Hospital Project Update

14 11:41 - Equality, Diversity & inclusion (ED&I) Annual Report
Chief People Officer
Item 14 Equality and Diversity Annual Report BOARD Sept 2024

15 11:51 - Complaints and PALS Annual Report 2023/24
Chief Corporate Services Officer
Item 15 Complaints and PALS Annual Report 2023-24 - Board

16 12:01 - Risk Management Report
Chief Corporate Services Officer
Item 16 Risk Management Report - September 2024

17 12:06 - Board Assurance Framework
Chief Corporate Services Officer
Item 17 Board Assurance Framework Report - September 24

18 12:11 - Board Committees Assurance Reports
Chairs of Board Committees
Item 18.1 Committee Assurance Report to Board - Finance Investment Committee
Item 18.2 Committee Assurance Report - Audit Committee 15.7.24
Item 18.3 Committee Assurance Report to Board - Workforce Development Committee

19 12:16 - Forward Plan
Chair

Item 19 Trust Board in Public Forward Plan 2024-25

20 12:19 - Questions from Members of the Public
Chair

Item 20 Placeholder Questions from Members of the Public

21 12:24 - Motion to Close the Meeting
Chair

Item 21 Placeholder Motion to Close the Meeting

22 12:26 - Resolution to Exclude the Press and Public
The chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business:
"That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."

23 12:28 - Next Meeting in Public: Thursday, 14 November 2024

TRUST BOARD MEETING IN PUBLIC

Thursday 05 September 2024, 10:00 -12:30 hours
Conference Room at the Academic Centre

AGENDA

Item No.	Timing	Title	Purpose	Lead	Paper
Introduction and Administration					
1	10:00	Apologies	Note	Chair	Verbal
2		Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda • 2024/25 Register of Interests – Board of Directors - Register of Interests - Milton Keynes University Hospital (mkuh.nhs.uk)	Note	Chair	Verbal
3		Patient Story	Discuss	Chief Nursing Officer	Presentation
4		Minutes of the Trust Board meeting held in public on 04 July 2024	Approve	Chair	Attached
5		Matters Arising and Action Log	Note	Chair	Attached
Chair and Chief Executive Updates					
6	10:20	Chair's Report	Note	Chair	Verbal
7	10:25	Chief Executive's Report a. BLMK ICB September 2024	Discuss Note	Chief Executive	Verbal Attached
Patient Safety					
8	10:35	Patient Safety Update	Discuss	Chief Medical Officer/Chief Corporate Services Officer	Attached
Patient Experience					
9	10:45	Maternity Assurance Group Update	Discuss	Chief Nursing Officer	Verbal

Item No.	Timing	Title	Purpose	Lead	Paper
Performance					
10	10:50	Performance Report	Discuss	Chief Operating Officer	Attached
Break 11:00 (10 mins)					
Finance					
11	11:10	Finance Report	Discuss	Chief Finance Officer	To Follow
Workforce					
12	11:20	Workforce Report	Discuss	Chief People Officer	Attached
Estates					
13	11:30	New Hospital Project Update	Discus	Deputy Chief Executive	Verbal
Assurance and Statutory Items					
14	11:35	Equality, Diversity & inclusion (ED&I) Annual Report	Note	Chief People Officer	Attached
15	11:45	Complaints and PALS Annual Report 2023/24	Note	Chief Corporate Services Officer	Attached
16	11:50	Risk Management Report • Corporate Risk Register • Significant Risk Register	Discuss	Chief Corporate Services Officer	Attached Supplementary Shelf
17	12:00	Board Assurance Framework	Discuss	Chief Corporate Services Officer	Attached
18	12:10	Board Committees Assurance Reports • Finance & Investment Committee • Audit Committee • Workforce & Development Assurance Committee	Note	Chairs of Board Committees	Attached
Administration and Closing					
19		Forward Plan	Note	Chair	Attached
20		Questions from Members of the Public	Discuss	Chair	Verbal

Item No.	Timing	Title	Purpose	Lead	Paper
21	12:20	Motion to Close the Meeting	Approve	Chair	Verbal
22		Resolution to Exclude the Press and Public The Chair to request the Board pass the following resolution to exclude the press and public and /move into private session to consider private business: "That representatives of the press and members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."	Approve	Chair	
12:30		Close			
Next Meeting in Public: Thursday, 14 November 2024					

Quoracy: This meeting shall be deemed quorate with not less than 3 voting Executive Directors (one of whom must be the Chief Executive or acting Chief Executive) and 3 voting Non-Executive Directors (one of whom must be the Chair or Deputy Chair).

	MEMBERS	
1	Heidi Travis	Non-Executive Director - Acting Chair
2	Joe Harrison	Executive Director- Chief Executive Officer
3	Gary Marven	Non-Executive Director
4	Haider Husain	Non-Executive Director
5	Dev Ahuja	Non-Executive Director
6	Mark Versallion	Non-Executive Director
7	Sarah Whiteman	Non-Executive Director
8	Precious Zumbika-Lwanga	Associate Non-Executive Director
9	Ganesh Baliah	Associate Non-Executive Director
10	John Blakesley	Executive Director - Deputy Chief Executive
11	Ian Reckless	Executive Director - Deputy Chief Executive
12	Emma Livesley	Executive Director
13	Helen Beck	Executive Director
14	Fiona Hoskins	Executive Director
15	Kate Jarman	Executive Director
16	Jonathan Dunk	Executive Director

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 05 September 2024

Apologies

Heidi Travis
Chair

Verbal/ Note

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 05 September 2024

Declarations of Interest

- Any new interests to declare.
- Any interests to declare in relation to open items on the agenda.

Heidi Travis
Chair

Verbal/Note

TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 05 September 2024

Patient Story

Fiona Hoskins
Chief Nursing Officer

Presentation/Discuss

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Minutes of the Trust Board of Directors Meeting in Public held on Thursday, 04 July 2024 at 10.00 hours in the Academic Centre, Milton Keynes University Hospital Campus and via Teams

Present:

Heidi Travis (Chair)	Acting Trust Chair	(HT)
Joe Harrison	Chief Executive Officer	(JH)
Gary Marven	Non-Executive Director	(GM)
Haider Husain	Non-Executive Director	(HH)
Sarah Whiteman	Non-Executive Director	(SW)
John Blakesley	Deputy Chief Executive	(JB)
Dr Ian Reckless	Chief Medical Officer	(IR)
Danielle Petch	Chief People Officer	(DP)
Steve Beaumont	Interim Chief Nursing Officer	(SB)
Emma Livesley	Chief Operating Officer – Planned Care	(EL)
Helen Beck	Chief Operating Officer – Unplanned Care	(HB)
Jonathan Dunk	Chief Finance Officer	(JD)

In Attendance:

Tom Daffurn	Public Governor	(TD)
Babs Lisgarten	Lead Governor	(BL)
Ansar Hussain	Milton Keynes Council	(AH)
Andy Forbes	Public Governor	(AF)
Christine Thompson	Public Governor	(CT)
Kate Jarman	Chief Corporate Services Officer	(KJ)
Jacob Pritchard	Head of Communications and Engagement	(JP)
Adelaide Atu (For item 3)	Lead Nurse - Quality & Ward Accreditation	(AA)
Jason Sinclair	Associate Non-Executive Director	(JS)
Ganesh Baliah	Associate Non-Executive Director	(GB)
Precious Zumbika-Lwanga	Associate Non-Executive Director	(PZL)
‘Kemi Olayiwola	Trust Secretary	(KO)

1 Welcome and Apologies

1.1 The Chair welcomed all Board members in attendance and recognised those attending virtually. The Chair also recognised the Governors who were in attendance in person and over Teams.

There were apologies from Dr Dev Ahuja, Non-Executive Director and Mark Versallion, Non-Executive Director.

The Chair highlighted that it was JS’s last Trust Board meeting as their 2 years Associate Non-Executive Director term would come to an end on 31 August 2024. It was also noted it was DP – Chief People Officer last Trust Board at MKUH as she would be leaving to join Nottingham NHS in August 2024. Leaving Board members would be thanked later in the meeting.

2 Declarations of interest

2.1 There were no new interests to declare.

The Chair highlighted that declaration of interest was a continuous exercise and urged members to update their interests as soon as such interest arise.

There have been no issues raised.

3 Staff Story

3.1 The Staff Story was narrated by Adelaide Atu (RGN) the Quality and Accreditation Lead nurse at MKUH. AA grew up and received her professional training in Ghana. She has spent a period of 25 years in the NHS, 21 years of which had been spent in MKUH. Her career development spanned through different roles varying from staff nurse, deputy ward manager, ward manager and lead nurse. In 2021, she earned the title of Chief Nurse Fellow and now serves as the Quality and Accreditation Lead Nurse at the hospital.

3.2 AA highlighted the positive impact the Trust had made on her career development and progression particularly in the area of courses and trainings attended including but not limited to managing critically ill patients, leadership, and coaching. She noted the significant development opportunities that were sponsored by the Trust that she had benefitted from during her career. Those trainings and developments have helped to build her confidence to become a better professional, manager and colleague. She now provides mentoring support to her fellow international nurses while also encouraging them in making growth-enhancing career development choices.

3.3 In terms of her experience as an immigrant nurse, she highlighted the positive experiences she had over the years as well as the not so positive experiences particularly in the area of staff management, work-life balance, finding the right studies to support her development and most importantly, her journey through overcoming discrimination from some of her peers.

3.3 In response to the GM's and GB's questions about the improvements that the Trust could make towards international recruitment and retention of healthcare professionals, AA recommended that the Trust could invest in talent hunting within its current staff population, provide adequate support, and opportunities for development as this will improve employee retention rate while also attracting talents to the Trust. She further highlighted that the Trust could do more with English language lessons for newly recruited international staff to ease their integration into the system particularly because most do not speak English as their first language.

3.4 HH thanked AA for all the good work she has done in the Trust, for her bravery, leadership, and resilience over the years, noting that her story is a testament that she is a role model to her colleagues and junior staff members.

3.5 On behalf of the Board, HT thanked AA for the story and wished her well for the future.

4 Minutes of the Trust Board Meeting in Public held on 2 May 2024

4.1 The minutes of meeting held on 2 May 2024 were **approved** subject to the following amendments on:

- Page 5 – *Typographical error on the appraisal compliance percentage **should be 92%** not 9%;*
- Page 10 (10.3) – *Note accurate*

5 Matters Arising and action log

5.1 There were no open actions for review

There were no matters arising.

6 Chair's Report

6.1 HT provided a verbal update of the Chairs Report and highlighted as follows:

Volunteer Award
The recent volunteer award session was a delightful event celebrating the contributions of volunteers across the Trust. This event was well-received by all attendees.

Staff Award
HT was privileged to have attended the staff awards on 7 June 2024. The event was well organised, and she was delighted to have presented awards to very well-deserving members of staff who had been nominated by their peers across the Trust for their good work at the hospital. The event was well-attended by Board members and Governors.

Armed Forces Day
HT had attended the Armed Forces Day, an annual event held on 29 June 2024 to celebrate the veterans She was privileged to have met Christine Thompson (Public Governor) at the event.

Governors' Community Engagement Activities
There had been various significant activities in the past month. It was noted that governors had been actively involved in spreading positive news and developments across the Trust.

Committee Chairs - Update
HT provided an overview of the changes to committees' leadership and confirmed that MV would now chair Audit Committee while GM had commenced chairing of Finnance and Investment Committee. SW had joined Quality & Clinical Risk Committee and Workforce & Development Assurance Committee as a member. It was noted that SW would chair the Maternity Assurance Group

GovernWell Joint-Session for NEDs and Governors
HT provided an update on the GovernWell Training session that was recently organised by the Trust for NEDs and Governors to support them in their work. The training was facilitated by NHS Providers and took place on 30 May 2024. It was an informative session that was intended to support the Board in their journey of building a productive relationship with the governors while changing the ways both parties work together in the overall interest of the patients we serve.

New ways of working with the governors have been identified and developed, while some are currently being implemented. It was noted that formal Council of Governors meeting will now be alternated with 'Open Forum' in place of informal meetings. The cycle of business for the open forum was being developed and the first draft will be shared with the Council of Governors on 24 July 2024.

Meetings with Governors & NEDs
HT organised and conducted one-on-one meetings with several NEDs and Governors over the past few weeks. A few members were scheduled to meet with her in the coming weeks. These meetings have facilitated helpful conversations and the establishment of strong relationships.

6.2 HT joined the Board to thank DP for the good work she had done during her time as Chief People Officer and wished her well for the future

6.3 HT also joined the Board to thank JS whose term as Associate Directors would terminate on 31 August 2024, for their time and invaluable contribution to the trust. The Board wished them well for the future.

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

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

7.1 JH provided a verbal overview of the Chief Executive Officer's Report as follows:

Appointment of new Chief Nursing Officer and Chief People Officer
JH informed the Board that Fiona Hoskins, the new Chief Nursing Officer was planned to resume post the following Monday 8 July 2024. While highlighting the good work that was being undertaken by SB as interim Chief Nurse, he noted that it was SB's last Trust Board meeting.

JH further advised the Board that a new Chief People Officer had been appointed and undergoing preliminary onboarding processes. Formal details will be notified to the Board and the wider Trust in due course.

HT joined the Board to thank SB for the good work he did while in post on interim contract as Chief Nurse and wished him well for the future.

7.2 **Update on EDI work**

7.2.1 JH provided a summary of the outcome of the EDI work that was commissioned to Roger Klein. A formal report had been received and included in the Board pack and taken as read. It was noted that the implementation of the expert recommendations was underway and would span over the coming few months and years. It was further noted that the Board was vested with oversight of the implementation and therefore will receive regular updates on progress at Public Boards in respect of same.

Action: *Update on EDI progress to be presented to Public Board as an* ***open Performance action- JH/KJ/CPO***

7.3 In relation to elective waiting times, JH advised that the Trust had attained a tier 1 status for NHS performance management. By implication, there would be more frequent engagements with both the national and the regional teams of NHS England. It was noted that the Trust was deploying all its resources into ensuring that waiting times are significantly reduced over the following months. Regular updates on progress will be presented to the Trust Board over the next several months.

7.4 IR provided an update on the ongoing junior doctors' industrial action, noting its significant impact which was managed with the help of specialty doctors and consultant staff. Approximately 350 planned care episodes, mainly outpatient appointments, were affected. It was noted that a new government – once in-situ – may offer an opportunity to move national negotiations forward.

7.5 JH informed the Board about the first team MKUH Expo planned to be held on Thursday 11 and Friday 12 July 2024. He highlighted that the sessions were dedicated to different themes aligned with the Trust's strategies, which were people, digital and estate. While the publicity of the event was noted as ongoing, staff were encouraged to attend in person or watch the recording if unable to attend in person.

7.6 '*My Thank You'* was launched by the MKUH Charity as an opportunity for patients, their relatives and visitors to leave messages of gratitude to staff and volunteers who had made a difference to their care and their experience during their stay at the hospital.

7.7 JH provided update on car parking. He noted that discussions and consultations were ongoing, while options were being considered to best the manage the short-term challenges surrounding parking on site. The management is not oblivious of the difficulties being faced by staff and patients at this time. While efforts were being made to move more staff to Witan Gate to relieve the pressure at the hospital, conversations were ongoing with the Council on formalising agreements on one of the neighbouring carparks. Regular updates on progress will be presented to the Board.

The Board noted that the car park behind the Academic Centre was being closed to build the multi-storey parking

7.8 The Health and Safety report was discussed as part of Item 20

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

8 Serious Incident and Learning Report

8.1 KJ introduced the Serious Incidents Report as part of the Integrated Quality Governance Report listed as item 20 on the agenda.

8.2 The discussion emphasised the increased engagement in learning and communication among staff, with a positive response to the new reporting system (Radar). The daily triage meetings and the new reporting system was credited with improving the understanding and handling of significant incidents.

It was noted that Radar's inclusivity and focus on learning has resulted in increased incident reporting. The importance of measuring success through collected data and comparing it across different organisations was discussed.

***Action**: IR to review the staff survey questionnaire to ensure whether adequate questions relating to 'staff feeling safe to raise incidents' are well incorporate to ensure the right feedback is aggregated for mapping purposes.*

8.3 There were discussions on the ability to identify thematic issues from minor incidents. It was noted that understanding low-level issues collectively could prevent larger problems. The Trust's approach to addressing thematic concerns and soft intelligence methodologies was highlighted as a future focus area.

8.4 The new Integrated Governance Report was introduced, covering areas such as complaints, patient experience, health and safety reporting, information governance, quality improvement, and Care Quality Commission compliance. The report aimed to provide the board with oversight and prompts for further exploration in committee meetings.

8.5 A particular focus was placed on Health and Safety improvements. The Trust was concentrating on reducing violence and aggression, with structural changes being made to support this effort, including recruiting a violence and aggression reduction lead and enhancing the Health and Safety team.

8.6 KJ noted that the Integrated Governance Report was still evolving and developing. She invited the Board to provide feedback on what they would like to see included in the report.

8.7 The Board noted that going forward Serious Incident and Quality Improvement Report will form part of the Integrated Governance Report.

8.8 The Board **noted** the Serious Incident and Quality Improvement Report.

9 Chief Nursing Officer Update

9.1 **Bi- Annual Staffing Report**

- Vacancies across Registered Nurses, Midwives and therapist continued to reduce, and there was a good Registered Nurse (RN) fill rate.
- A review was being undertaken with regards to the paediatric nurse staffing and the responsibility and funding of paediatric HDU beds was being discussed with commissioners. Nurse staffing on ICU was being reviewed.

Maternity Staffing

- A vacancy rate of 9.9% was recorded in March 2024. The supernumerary status of the labour Ward coordinator was achieved between 99.3% to 100% from October 2023 to March 2024.
- There had been an increase in births, which had led to ongoing escalation in maternity.

Annual Falls Report – Apr 23 – Mar 24

- Annual falls report showed continued issues with both witnessed and unwitnessed falls. Actions were being taken to address this. Overall, there had been a 1% reduction in falls.
- There was an increase in patients with challenging behaviour, impacting the fall rates.

Hospital Acquired Pressure Ulcers (HAPU) Report Apr 23 – Mar 24

- Between the reporting period, there were 213 reported HAPUs across all categories. This represents a 51.5% reduction compared to the previous year. However, the number of Moisture Associated Skin Damage (MASD) incidents had seen a steady increase. A quality improvement programme had been initiated to address this.

9.2 In response to the query about the high rate of unwitnessed falls, SB explained that the high rate of unwitnessed falls was due to patients' independent actions without calling for help. Bed Watch and other systems had been implemented to reduce these instances, although completely eliminating

unwitnessed falls remained a challenge. Tracking patient journeys and monitoring falls in single patient rooms was part of ongoing effort to improve patient safety.

9.3 The Board **noted** the Chief Nursing Officer Update

10 Maternity Assurance Group Update

10.1 SB presented an overview of the matters discussed and reviewed at the Maternity Assurance Group meeting for April 2024 and May 2024. The following was highlighted from the report:

- **PQSM**: April had 3 moderate harm incidents; May had 2. Training compliance rates varied, with notable areas for improvement in PROMPT coverage.
- **PMRT**: Quarterly report reviewed neonatal and maternal deaths; May reported 8 losses under 22 weeks with no eligible MBRRACE/PMRT cases.
- **CQC Picker Action Plan**: Highlighted improvements needed in pain management, support during labor, and infant feeding. Updated QIPP action plan with feedback from 2022 and 2023 surveys.
- **60 Steps Review**: Identified 21 areas for improvement; actions added to QIPP for monitoring and shared with ICB and LMNS.
- **FASP Action Plan**: November 2023 quality assurance visit led to several closed actions with ongoing monitoring for remaining recommendations.
- **Midwifery Workforce**: Report noted increased sickness absence and improved BR+ confidence factor at 87%, with continued monitoring.
- **ATAIN**: Quarterly report showed fluctuating term admission rates, with respiratory issues as the leading cause.
- **Triage/BSOTS**: Ongoing review to address increased waiting times and improve service user pathways.
- **MNSI Reports**: Three final reports with safety recommendations and action plans under progress monitoring.

10.2 The Board **noted** the Maternity Assurance Group Update and **noted** that the Maternity Assurance Group meeting will now be chaired by Sarah Whiteman (Non-Executive Director)

11 Performance Report Month 2

11.1 EL presented the Performance Report for Month 2 touching upon various operational aspects and challenges faced by the Trust.

11.2 There were over 9,000 Emergency Department (ED) attendances in May 2024, which was 662 more than the previous month. The percentage of attendances admitted, transferred, or discharged within 4 hours was 73.3%, a decline from 74.0% in April 2024. 77.3% of ambulance handovers took less than 30 minutes, and 95.5% took less than 60 minutes. The number of inpatients not meeting the criteria to reside at the end of May 2024 was 95 against a threshold of 50. This was a deterioration compared to 78 reported last month.

11.3 Efforts were currently focused on addressing staffing issues, particularly in nursing and leadership positions. Discussions were ongoing about providing additional support for overnight doctors.

11.4 There were slight improvements in long-stay patient metrics. The number of super stranded patients at the end of the month was 120. This was an improvement compared to 129 reported in April 2024. Focus remained on enhancing ED handovers and discharges. However, diagnostic performance saw a 1% decrease, with over 12,000 patients waiting for diagnostics over 6 weeks.

11.5 The end of quarter four showed improvements in the 28-day and 31-day cancer targets. The 62-day target improved to 73%, but capacity and diagnostic challenges remained. In terms of outpatient metrics, a concerning decline in outpatient attendance was noted. Issues identified with reminder letters and contact processes was under review.

11.6 In terms of elective recovery, discussions focused on the need to refine reporting and concentrate on crucial recovery metrics with emphasis on reducing the number of patients waiting over 65 weeks.

11.7 The Board **noted** the Performance Report for Month 2

12 Finance Report Month 2

12.1 JD reported a deficit a deficit position of £2.3m to the end of the May 2024 which was £0.3m worse than planned. He stated that the Elective Recovery Fund (ERF) performance was currently above the 106% target, with income showing £2.7m above the national target as at M02 resulting in a favourable income variance to plan of £0.9m.

12.2 The Finance and Investment Committee recently reviewed the Trust's efficiency program, noting substantial progress despite challenges. JD noted that second half of the year was critical for mobilising and delivering these efficiencies. Additionally, national classification activity could impact income, but this was closely monitored to gauge its material impact.

Action: *Provider Selection Regime and the potential implications of this for the Trust/ICS to be briefed by JD at the Trust Board Seminar in October 2024.*

12.3 The Board **noted** the Finance Report for Month 2 and **agreed** that virtual approvals will be sought over the next few months.

13 Workforce Report

13.1 DP presented key highlights from the workforce report:

- **Statutory and mandatory training compliance** was at 96% and appraisal compliance is at 92%.
- **Healthcare Support Worker Vacancies**: 87 vacancies currently exist, highlighting ongoing challenges.
- The first **Temporary Staffing Taskforce Meeting** was held in M3 (June 2024) to review temporary staffing usage and spend with increased scrutiny across the Divisions. Areas of focus were bank and overtime, and the group will be sharing data on hotspot areas to support with improved efficiencies
- The Trust's **Gender Pay Gap** report showed improvements in median pay gap and would being presented to Workforce Development and Assurance Committee in M4 (July 2024). A full Equality, Diversity and Inclusion report would be prepared to review performance against national benchmarks and to evidence progress over the last 12 months; this will include the pay gap, WRES and WDES performance data.
- **Windrush Day**: The Trust successfully honoured Windrush Day which took place in June 2024 with well-attended events and shared experiences.
- **Temporary staffing usage** had dropped slightly to 12% with a 2.3% improvement in cost from the beginning of the financial year 2023/24. Bank usage was under review to ensure that all Nursing and Healthcare Support Worker requests were scrutinised by senior nursing prior to being paid on Health Roster.

13.2 The Board **noted** the Workforce Report

14 Freedom to Speak Up (FTSU)

14.1 DP reported a rise in referrals to the Freedom to Speak Up (FTSU) Service, indicating greater staff comfort in raising concerns. The main themes of the referrals involved intolerance of poor behaviours. Training and recruitment for champion roles had also increased.

14.2 The Lead Guardian retired, and a new Guardian joined the Trust in June. The Guardian role, previously part-time, is now a full-time position with increased investment in protected time for guardians and

champions. The office had been relocated to a more accessible area near the hospital's restaurant to enhance visibility and accessibility.

14.3 Given the increasing number of cases, there was a discussion about whether the team size was adequate. It was noted that the new full-time guardian would impact resource allocation, and there was potential to increase the number of champions if needed. Concerns about anonymity and the ability to gather comprehensive data were raised. While multiple avenues for anonymous reporting exist, there were challenges in ensuring complete anonymity and collecting detailed demographic data.

14.4 There was a focus on reducing workplace violence, with efforts aligned to the Freedom to Speak Up resources to better support staff and ensure both physical and psychological safety.

13.2 The Board **noted** the Freedom to Speak Up (FTSU) Report

15 Risk Register Report

15.1 KJ presented a report analysing all risks listed on the Risk Register as of 5 June 2024.

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

16 Board Assurance Framework (BAF)

16.1 KJ presented the Board Assurance Framework (BAF) and requested Board approval for two new risks:

1. Deteriorating quality of the estate
2. Data/Cyber Security

The Board agreed that a deep dive into the BAF vis-a vis the new risks proposed was required, however due to the limited time of the Board, could not be achieved. *It was unanimously agreed that a deep dive into the BAF and a review of the new risks will be undertaken at the Board Seminar in October 2024 – **Board Action***

Monitoring by Finance and Investment Committee (FIC): FIC will monitor the risk of insufficient capital funding to meet the needs of the population we serve with caution. There was potential for this risk to increase to a 25 rating over the next quarter, though it currently remained at a 20 rating.

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

17 (Summary Reports) Board Committees

17.1 GM (FIC Chair) noted that while finances were on target, there was a potential risk related to the Integrated Care Board (ICB) affecting their triple lock status.

18 Use of Corporate Seal

18.1 The Board **noted** the update on the use of the Corporate Seal in accordance with the Trust's Constitution and the **schedule** of the use of corporate seal 2024/25

19 Modern Slavery and Human Trafficking Statement 2024

19.1 KJ presented the MKUH Modern Slavery and Human Trafficking Statement 2024 to the Board for approval. It was noted as a governance and compliance requirement in line with NHSE requirement for provider Trusts as follows:
"*In accordance with section 54(1) of the Modern Slavery Act 2015, Milton Keynes University Hospital NHS Foundation Trust should publish a Modern Slavery and Human Trafficking Statement on the steps*

it has taken in the previous year to ensure that modern slavery (i.e. slavery and human trafficking), is not taking place in any part of its own business or any of its supply chains".
This statement must be approved by the Board and made publicly available.

19.2 The Board **noted** and **approved** the Modern Slavery and Human Trafficking Statement 2024

20 Integrated Quality Governance Report

20.1 Discussed on item 8

21 Forward Agenda Planner

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

The Board **noted** the Forward Agenda Planner *subject to an amendment of the September meetings to include the items for discussion. - Trust Secretary*

22 Questions from Members of the Public

22.1 The below question was received from governors and members of the public:

1. Are there areas in the hospital that are chronically understaffed resulting in suboptimal patient management? If there are, what efforts are being made to resolve the understaffing? Have agency staff been considered to fill these gaps in the short-term pending recruitment?

CEO's (JH) Response:
The hospital is generally well-staffed, though certain subspecialties, like Paediatric Emergency and Paediatric Urology, face recruitment challenges. These are national issues. Efforts include targeted recruitment and comprehensive health and well-being programs for staff. Agency staff are used as needed to maintain safe staffing levels, utilising NHS-approved frameworks. Specific plans are made for hard-to-fill posts, including diverse advertising and competitive packages. Staffing is checked twice daily across the hospital.

23 Any Other Business

23.1 None

The meeting closed at 12:00PM

Updated:19.08.24.

NHS
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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
36	05-May-24	15	October Board Seminar: Risk Development Programme	Revisit and refresh the risk management strategies and commitment to continued education and adjustment to enhance risk management across the organisation.	Paul Ewers/KJ	03-Oct-24		**Open**
37	04-Jul-24	7	Chief Executive's Report – Overview of Activity and Developments	Update on EDI progress to be presented to Public Board as an open Performance action	JH/KJ/Chief People Officer	**05-Sep-24**		**Open**
38	04-Jul-24	8	Serious Incident and Learning Report	Review the staff survey questionnaire to ensure whether adequate questions relating to 'staff feeling safe to raise incidents' are well incorporate to ensure the right feedback is aggregated for mapping purposes	IR/Chief People Officer	**05-Sep-24**	**19.08.24:** **The following are standard questions in the annual staff survey:** **In the last month have you seen any errors, near misses or incidents that could have hurt staff and/or patients/service users (No).** **My organisation treats staff who are involved in an error, near miss or incident fairly (Agree/Strongly agree).** **My organisation encourages us to report errors, near misses or incidents (Agree/Strongly agree).** **When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again (Agree/Strongly agree).** **We are given feedback about changes made in response to reported errors, near misses and incidents (Agree/Strongly agree).** **I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).** **I am confident that my organisation would address my concern (Agree/Strongly agree).** **Recommend to close**	**Completed**
39	04-Jul-24	12	Finance Report Month	Provide a Provider Selection Regime and the potential implications of this for the Trust/ICS Report at the Trust Board Seminar in October	JD	03-Oct-24		**Open**
40	05-Jul-24	Action from TEC	TEC meeting held 12/06/24 **Board Assurance Framework**	Due to the absence of the risk owner, an update on the Emergency Department (ED) RS4 BAF risk was to be provided at the next Board meeting.	Emma Livesley/Paul Ewers	**05-Sep-24**	**22.08.24:** **Meeting held between EL and PL. BAF risks all up to date.** **Recommend to close**	**Completed**
41	04-Jul-24	16.1	Board Assurance Framework (BAF)	Board Action: Conduct a deep dive into the BAF and review the new risks at the Board Seminar in October 2024, as unanimously agreed by the Board.	HT/KJ/KO/ Paul Ewers	03-Oct-24		**Open**

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TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 05 September 2024

Chair's Report

Heidi Travis
Chair

Verbal/Note

TheMKWay

NHS
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University Hospital
NHS Foundation Trust

TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 05 September 2024

Chief Executive's Report

Joe Harrison
Chief Executive

Verbal/Discuss

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date 5 September 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: Heidi Travis, Acting Chair, Milton Keynes University Hospital NHS Foundation Trust

Report Author: Maria Wogan

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

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

1.0 Executive Summary

The ICB Board met in Central Bedfordshire Council offices on 19 July 2024. This report is a summary of the items discussed at that meeting, with full papers and minutes available at Board Meetings - BLMK Integrated Care Board (icb.nhs.uk).

2.0 Recommendations

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

3.0 Key Implications

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

4.0 Report

4.1 **Questions from Residents** - Two residents submitted questions, one on cardiac rehabilitation services for residents in Dunstable and Houghton Regis and the other on meetings between NHS Foundation Trust Governors and the ICB. The questions and responses can be found on our website Board Meetings - BLMK Integrated Care Board (icb.nhs.uk).

4.2 **Acting on Resident Feedback** - Each quarter residents' stories come to the Board, showcasing our work and providing important insight into its impact on local people and communities. This quarter the Board was joined by three residents who had undertaken apprenticeships in healthcare through employment with ELFT, Central Bedfordshire Council and Cambridgeshire Community Services NHS Trust. They reflected on the roles they had secured post apprenticeship, and discussed the flexibility to study and work and the opportunity the apprenticeship had given them

to commence fulfilling second careers with the life changing impact this had on them and their families.

4.3 **Strategic Priorities** - Following the Children and Young People Board Seminar in November 2023, the Board was updated on the work being undertaken under the 'Start Well' priority, and the co-production work that is driving quality improvement. This included changes to language to break down barriers for children, young people and their families. The board also heard how work is underway to assess fragile services and create a system wide approach to increasing the pace to improve services for children and young people.

4.4 **The Joint Forward Plan and Operational Plan** - The Board were briefed on the ICB's work to refresh the Joint Forward Plan and Operational Plan for 2024/25. A balanced operational plan was submitted to NHS England and the Board heard how we are working in a challenging financial environment with c. £55m of unmitigated financial risk in the system. This comes at a time when partners are working to deliver demanding national targets including reducing waiting times and increasing the pace of diagnostics. The ICB recently agreed 11 priorities for transformation and is implementing a "Data Pyramid" approach to evidence the impact of transformation to improve outcomes for the population. The Board welcomed the new Portfolio Report which brings together all the transformation work across the system.

4.5 **A Refresh of the Working with People and Communities Strategy** - Following publication of the Denny Review, insights from partners and two years of collaboration via the Working with People and Communities Committee, the Board approved the refresh of the strategy. The strategy focuses on implementation of the recommendations from the Denny Review, embedding co-production approaches and introducing a new System Insight Network to replace the Working with People and Communities Committee. Members of the Committee were thanked for their significant contribution.

4.6 **BLMK ICS Staff Survey Results** - The results from the recent staff survey show an increase in participation compared to previous years and a positive trend in results, despite the challenging context. Some ICB Partner organisations, particularly ELFT and CCS, rated highly in the staff survey results. The Board was assured that work with trade unions and staff was ongoing, and learning taken from other trusts to continue to increase participation.

4.7 **Acute Hospital Emergency Activity** - The latest hospital attendance data was shared with the Board, showing that during the year April/May 2023 to April/May 2024 there had been a 7% increase in the number of people attending BLMK's hospitals (a 24% increase at Bedford Hospital, 8% at Luton and Dunstable Hospital and 2% at Milton Keynes University Hospital), impacting performance. Further work to understand the reasons for this increase in demand has been undertaken and work with partners is underway to manage flow, with opportunities to change the way musculoskeletal, mental health and children's attendances are triaged to help support that.

4.8 **Committee Reports** - Chairs of the Committees of the Board provided reports on their areas of responsibility, which is to challenge and provide assurance that the ICB's statutory duties are being discharged appropriately.

4.9 **Reports from the ICB Chair and Chief Executive** - Reports were provided by the Chair and Chief Executive of the ICB providing an overview of their activity in the last quarter. Partners were thanked for their role in supporting the Annual Report and Accounts 2023/24. The Chief Executive reported NHS England's feedback from

review meetings, recognising the hard work of all system partners to achieve a balanced budget in 2023/24. Strong Place working, a good population health approach, and the use of population health intelligence were also recognised, as was the hard work involved in taking on responsibility and leadership for Specialised Commissioning.

4.10 **Place Based Reports** - Place Leaders reported on developments at Place, including:

- Delivering the neighbourhood working approach in primary care,
- Development of the Luton 2040 and MK2028 plans,
- Work to support people with substance misuse problems in Central Bedfordshire, and
- A neighbourhood text messaging pilot in Caldwell, Bedford to identify carers and offer support, undertaken by Carers In Bedfordshire.

4.11 **Corporate Governance** - The Board approved the terms of Reference for the Mental Health and Learning Disability Committee which included a change to quoracy to support decision making.

4.12 **Section 75 Agreements (Non-Better Care Fund)** - The Board agreed section 75 agreements for pooled funds for various services with Luton Council, and for the purchase of Integrated Community Equipment for Milton Keynes City Council.

4.13 **Next Meeting of the Integrated Care Board** - Will be at 9am on 27 September 2024, venue to be confirmed. The ICB Board will also present the full Annual Report and Accounts for 2023/24.

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

Board papers and a link to join the meeting is available here a week before the meeting: Board Meetings - BLMK Integrated Care Board (icb.nhs.uk)

4.13 **Other News**

BLMK Inequalities Week, w/c 13 May 2024 - BLMK was proud to host the first "BLMK Inequalities Week" w/c 13 May 2024. Many members of the Board and their organisations participated in these activities, and we're grateful for the cross-system efforts to make the events a success. The week started with the University of Bedfordshire hosted conference focussed on research and innovation, followed by the HSJ Tackling Inequalities Summit. Hundreds of BLMK staff and colleagues from partner organisations took part in partner-hosted webinars, including one led by Lloyd Denny, and the week concluded with the Creating a Fairer BLMK 2024 Event at the Rufus Centre in Flitwick. Our hope and expectation is that we will repeat this event in 2025 and annually thereafter as we make progress as a system.

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

List of appendices

None

Background reading

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

Meeting Title	Trust Board	**Date:** 05 September 2024
Report Title	Patient Safety Update	**Agenda Item Number: 8**
Lead Director	Dr Ian Reckless, Chief Medical Officer	
Report Author	Anna O'Neill, Patient Safety Specialist, Head of Patient Safety and Learning Specialist Dr Anna Costello, Patient Safety Specialist and Patient Safety Doctor	

Introduction	This paper provides Board with an overview of patient safety activity since the Trustwide launch of PSIRF on 01 May 2024. The paper seeks to familiarise Board members with the new systems in place whilst also providing oversight to the number and nature of the safety incidents reports, and the responses to them.		
Key Messages to Note	1. PSIRF was launched Trustwide on 01 May 2024: a variety of new systems and processes are now in place and embedding. 2. We remain in transition from the previous system – with root cause analysis of serious incidents, and the actions resulting, having a 'long tail' in terms of timescale. 3. The incident reporting rate is stable / increasing (an increase being a positive finding). 4. In PSIRF, the role of Trustwide triage (daily) and local patient safety huddles (typically at directorate level, weekly) is pivotal. 5. To date, 8 incidents [<0.5%] have led to level 1 patient safety incident investigations (PSII). 256 incidents [14%] have resulted in a patient safety learning response. 6. Emerging patient safety themes are described within the paper, along with examples of learning and staff feedback on the new processes.		
Recommendation	[x] For Information	[ ] For Approval	[ ] For Review

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

Report History	Last report shared July 2024.
Next Steps	In depth discussion at QCRC (16 September 2024), including upon format of routine reporting going forward.

Executive Summary

The Patient Safety Incident Response Framework (PSIRF) was launched at Milton Keynes University Hospital (MKUH) on 01 May 2024. This paper aims to give a brief overview of the purpose of PSIRF, how this is being implemented at MKUH and the initial data from having transitioned to PSIRF: data within the paper covers the period 01 May 2024 through until 20 August 2024. Much of this information has been shared in other forums within the Trust and is shared today for information and feedback from the Board.

Main Report

PSIRF represents a significant shift in the way the NHS responds to patient safety incidents. It supports Trusts to focus their resource and time into reviewing patient safety incidents where there is an opportunity to learn and to avoid repetition. This requires a considered and proportionate approach to the triage and response to patient safety incidents.

The introduction of PSIRF is a major step to improving patient safety management and will greatly support MKUH to embed the key principles of a patient safety culture which includes:

- Using a system-focused approach to learning (The SEIPS model[1], *Appendix 1*)
- Focusing on continuous learning and improvement
- Promoting supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all

Patient safety incidents at MKUH are reviewed in a 2-stage process; a daily Trust wide triage panel and weekly locally led patient safety huddles. The two stages allow for both Trust wide and local oversight and learning.

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

Trust wide triage includes a broad membership with representation from all key clinical areas (including patient safety, corporate nursing, medical, pharmacy, maternity, paediatrics, radiology, pathology, safeguarding). The local patient safety huddles are smaller groups and include representation from patient safety, operations, medical and nursing at either divisional or clinical directorate / clinical service unit (CSU) level. Both panels are responsible for appropriately grading all patient safety incidents using the 4 MKUH response levels *(Appendix 2)*. A key role of a local patient safety huddle is to review any level 4 incidents requiring further information and determine an appropriate learning response. A rapid review form is completed by the ward/department within 7 days of the incident being discussed at daily Trust wide triage. The questions in the form are based on the following national criteria:

i. potential for learning in terms of:
   - enhanced knowledge and understanding
   - improved efficiency and effectiveness
   - opportunity for influence on wider systems improvement

ii. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)

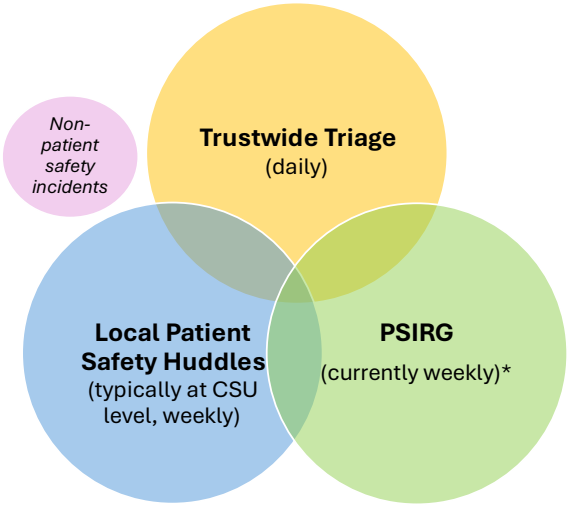
iii. likelihood of recurrence (including scale, scope and spread)

Based on the rapid review findings, the members of the local patient safety huddle agree to either close the incident on Radar or assign a level 1 or 2 response. For level 1 and 2 responses a learning event will be suggested. The details of the different types of learning events are described in *Appendix 3.* Broadly these events have replaced local investigations, 72-hour reports and root cause analysis (RCA).

The Trust wide triage panel formally reports to the Patient Safety Incident Review Group (PSIRG), weekly, and the Patient Safety Board monthly, for oversight. In addition, a daily update is sent to members of the executive group for their information.

Other processes exist for the review of non-patient safety incidents or for patient safety incidents where robust improvements strategies are already in place. Any complaints which may have a significant patient safety component are discussed at Trust wide triage.

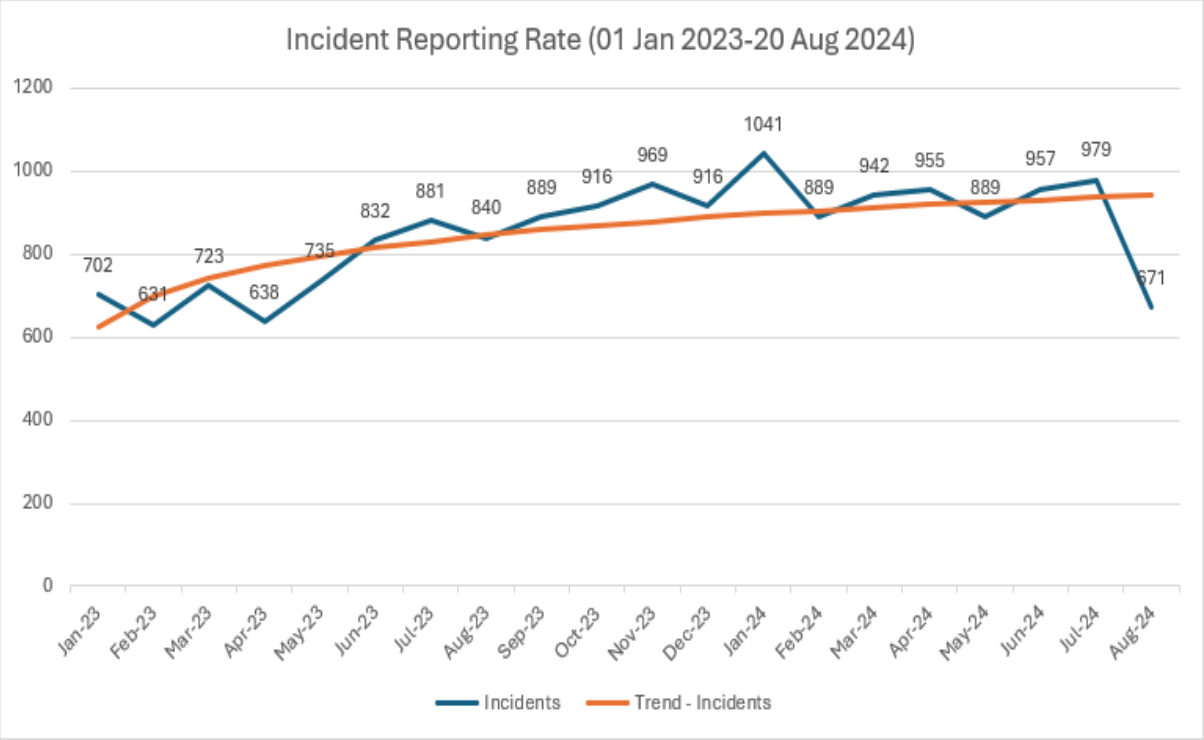
Key groups driving triage, understanding and management of reported patient safety incidents



* The frequency and format of PSIRG (patient safety incident response group) will be kept under review as the transition away from historic processes completes and as we optimise our focus on learning.

Outcomes (learning and actions) from learning events are shared in several different forums including local safety huddles, team newsletters, notice boards, in 'Spotlight on Safety' in the CEO newsletter as well as at the Trust wide learning forums such as PSIRG. Additional forums for sharing learning such as podcasts, drop-in sessions, Schwartz Round[2] style meetings, 'lunch and learn' sessions and simulation are being developed and will be launched in the coming months.

PSIRF Data 01 May – 20 August 2024



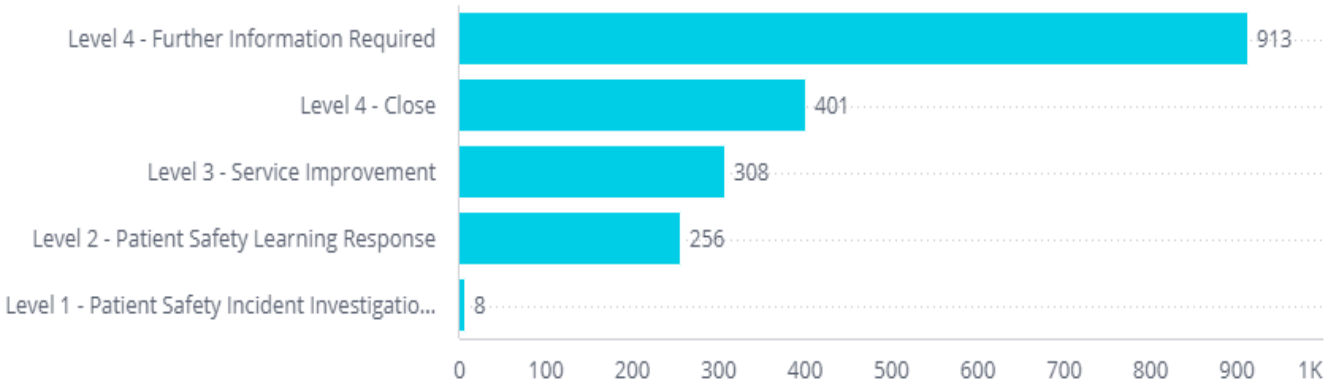
Up to 20 August, 671 incidents were reported in the month – giving (on a straight-line basis) a projected monthly total of 1040.

Patient Safety Incidents	Overdue level 4 incidents*
1898	113

*A delay of m*ore than 7 days from initial Trust wide triage to completion of a rapid review form and local discussion to determine an appropriate learning response.*

[2] Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. For further information Schwartz Rounds - Point of Care Foundation

Incidents levels allocated at daily Trust wide triage



Ongoing Level 1 Patient Safety Incident Investigations (PSIIs)

INC Number	Created Date	Safety Priority (National and Local)	Description
24255	05/06/2024	None	Inaccurate readings of HbA1c in the clinic following correlation to peripheral bloods. This has resulted in a number of children seen in the Paediatric Diabetes clinic receiving incorrect HbA1c results for some months. Lack of oversight of point of care machines.
24659	18/06/2024	None	30+5 neonatal death. Intrauterine rupture. Miscommunication around blood transfusion resulting in potential delay.
25330 / 25342	07/07/2024	Deteriorating Surgical Patients	Delay in escalation of deteriorating patient on Ward 20.
25503	12/07/2024	Delayed Diagnosis	Delay in listing patient for urgent exploratory surgery of 13 months. On procedure being undertaken histology confirmed rectal cancer.
26540	12/08.2024	Delayed Diagnosis	A case in which the management of a gynaecological malignancy was neither timely nor appropriate. Typographical error relating to diagnostics contributory.
26781	19/08/2024	Never Event	Bone marrow biopsy completed on the wrong patient. Similar features to a previous event involving failures in comprehensive positive patient identification.
24787	20/06/2024	None	Fall during seizure and head injury - Coronial case.
26824	20/08/2024	None	Aspiration Pneumonia - Coronial case.

Emerging Patient Safety Themes

Potential themes identified from reported patient safety incidents are actively tracked by the team. An identified theme may lead to specific actions (for example, co-ordination of an MDT meeting to discuss and improve understanding) which may not have been warranted based on a single incident. Identified themes may also assist in the identification of patient safety priorities for future years (as identified in the annual Quality Account).

Category	Source	Plan / next steps
Care of patients with learning disabilities	Incidents, Complaints, Section 42, LeDeR	Joint project with patient safety, QI and safeguarding team. MDT learning event being planned. Once learning event has been completed, further scoping may be required to inform Trust wide QI project.
Medications discharge errors (TTOs)	Incidents	Meeting with pharmacy and QI to reinstate QI project and agree process for responding to and learning from TTO incidents.
Completion of blood transfusion forms and blood bottle labelling	Incidents	MDT planned with blood transfusion team and ward managers. Collaboration with IT.
Drug history taking	Incidents	MDT planned 29.08.24.
Access to and availability of interpreter services (Trust wide)	Incidents	MDT to be arranged with external company.
Adherence to speech and language therapy (SALT) guidance	Incidents	MDT to be arranged.
Care and management of patients experiencing miscarriage in the Emergency Department	Incidents	MDT planned.
Management of iron infusion reactions	Incidents	MDT planned for beginning of September.
Weight loss in inpatients	Incidents	An MDT has already been held, further learning event to be arranged. Possible QI project.
Maternity post-natal discharges (particularly out of area discharges)	Incidents	Planned work within maternity, and possible QI project logged.
District nurse referrals for diabetic patients	Incidents	Been discussed at the diabetes safety meeting. Discussion and plan made with district nursing team.
Deceased patients' property	Incidents, Complaints	Corporate nursing team leading on improvement project with mortuary.
Positive patient identification	Incidents	A review will be part of recent never event (INC 26781).

Learning from Patient Safety Incidents

The patient safety team is capturing learning in a variety of ways including a new Mortality and Morbidity (M&M) meeting outcome form. This is a simple Microsoft form that encourages the M&M group to identify examples of care excellence, key learning and potential quality improvement opportunities. An outcome summary poster is developed monthly and shared across all CSUs for Trust wide learning. Please see example below:

Learning is identified during the daily triage meeting as all patient safety incidents are discussed with experts representing all departments of the hospital and during the weekly

PSIRG meeting. This learning is shared via the SOS message of the week and in the soon to be published patient safety newsletter.

Learning from level 2 learning events is captured and recorded on Radar and shared at relevant groups / meetings. A plan is being developed to present case studies and learning during plenary sessions throughout the year. This is a collaborative approach with the QI team to triangulate safety, improvement and audit. Below are some examples of learning generated from learning events since 01 May 2024.

Significant patient weight loss event:

- Importance of regular weighing and documentation of patients eating and drinking.
- When weight loss is identified, urgent referral to the dietician is required with review within 24 hours
- The MUST tool is not validated for patients with Learning Disability, so a detailed nutritional assessment needs to be carried out by a Dietitian.
- It is possible to track a patient's trend in weight loss/gain through the nurse workflow and vital signs section of eCare.

Cardiac event in the SDEC corridor:

- Improved communication between SDEC and ED streaming / ED Nurse In Charge could support informed decision making in regard to streaming patients to SDEC (when bedded).
- Ensuring the site team have updated knowledge of the SDEC situation each day can support appropriate requests for patients requiring admission.
- Re-configuration of the rooms in SDEC may allow more patients to be seen in rooms and less in corridors. Awaiting triumvirate and surgical SDEC approval.
- A change to the allocated rooms in SDEC would enable better use of rooms with oxygen and suction for patients.

Medication Dispensing Errors:

- Maintaining patient contact for teams who have limited contact can help to keep staff motivated and patient focused.
- Staff breaks are essential for both staff wellbeing and work effectiveness. Formalised break times can support staff concentration, reduce errors and minimise the risk of "checking fatigue" in repetitive tasks.
- Up to date, relevant training and updated policies support consistency in practice and reduce ambiguity for staff.
- Cluttered work environments can cause distractions and impact staff ability to concentrate. When clutter is within a team's gift to manage, for example stationery and stock that has not been put away, efforts must be made to tidy up.

Care of deceased patients:

- A full review of the types of slide sheets currently available to the support team is required. It is important that a "one size fits all" approach is not taken as there are various types of sheets/other equipment that can be used for different situations. The support team should be involved in this review.
- It is essential that all members of the support team receive appropriate moving and handling training, with focus on transferring deceased patients.

- It is imperative that bed spaces and/or side rooms are clear of unnecessary equipment and clutter. This ensures that there is as much useable space free when the support team arrive on the ward to collect the deceased. This is the ward staff's responsibility. The support team can move larger items i.e. bedside units were necessary and on assessing the area.
- There appears to be a gap in knowledge around roles and responsibilities following a patient's death. Whilst the nursing staff complete last offices, the other tasks such as ensuring slide sheets are in place, belongings gathered together in a respectful way, and property lists completed are tasks that are often not completed when the support team arrives.
- Trust training on care after death is not currently mandated. This means that nursing staff learn in the workplace, and for those working across different wards, they may not be required to care for deceased patients regularly.

Staff feedback from Learning Events

A new feedback form has been developed with a variety of feedback methods including satisfaction scales, images and free text. So far staff completing the form have rated learning events as either 'good' or 'excellent' and images chosen to describe how the learning events felt for them include:


Staff have shared comments such as:

"It was an excellent session. SEIPS model and different tools are amazing things to investigate and build learning"

"It worked well as we were able to talk about things openly and honestly and came out with some useful actions"

"Helped me to develop more insight into the incident and helps me to learn effective ways to prevent these types of incident"

"I felt safe discussing how I felt"

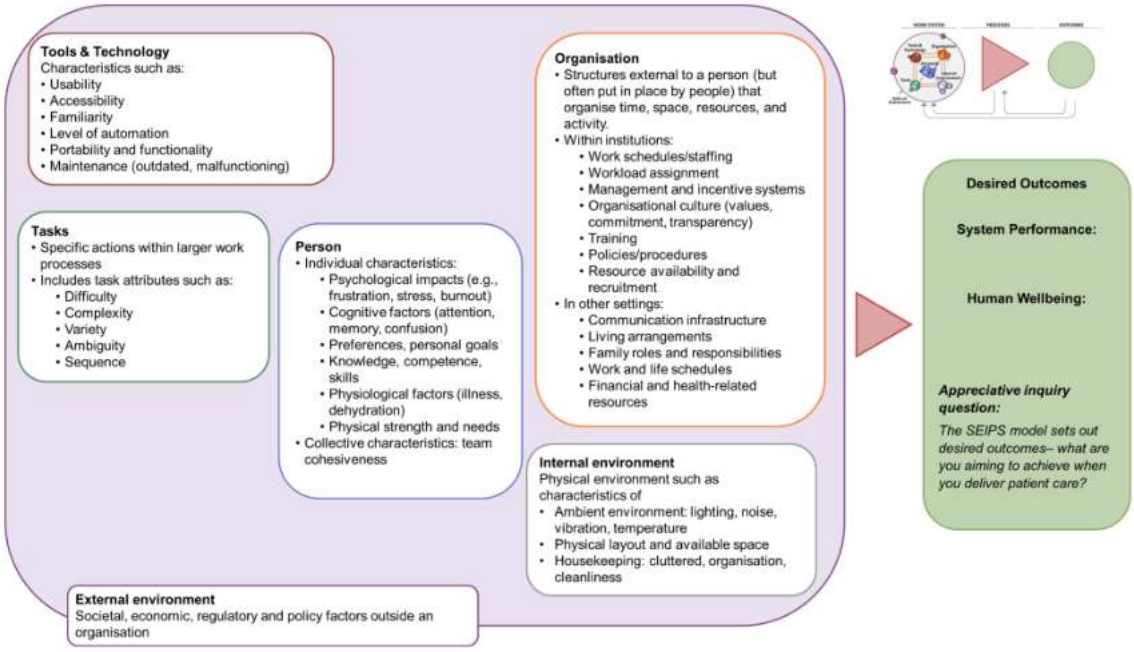
"I felt listened to"

Suggestions for improvement include opening the sessions up to others who may have been involved / experienced a similar incident and providing an overview of the incident details for those who may not have been involved in the specific incident.

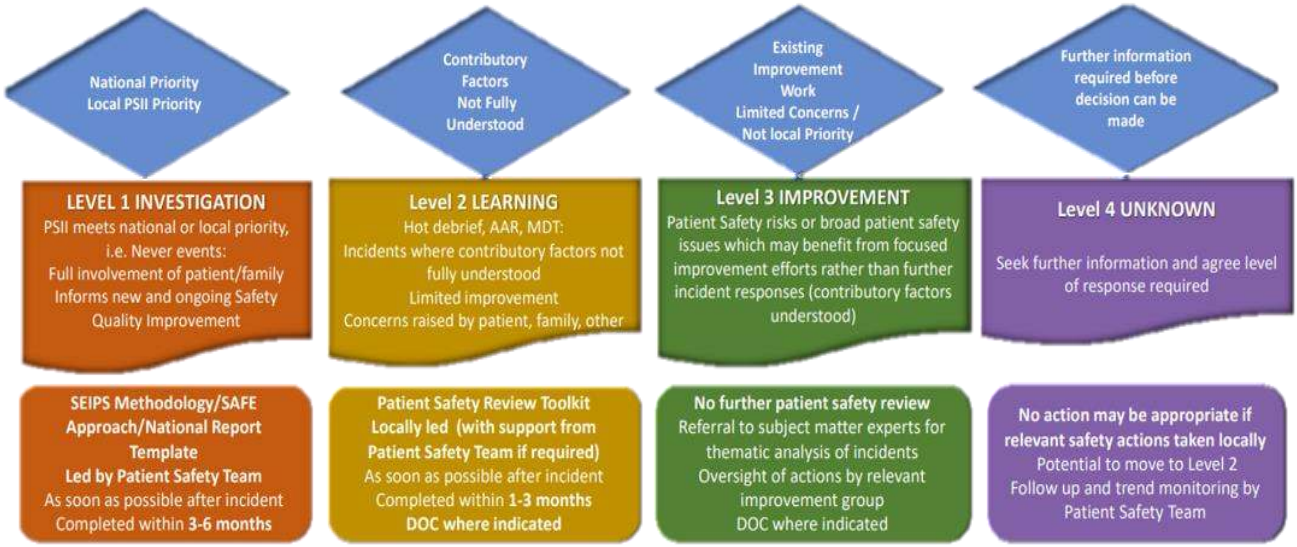
Appendices

Appendix 1 – The SEIPS model

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



Appendix 2 – Four response levels



Appendix 3: Types of Investigation and Learning Response Types

Response Type	Level	Description
Patient Safety Incident Investigation (PSII)	1	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. These are led by the central patient safety team to ensure standardisation of high-quality system focused reports in collaboration with experts in the relevant fields.
Hot Debrief	2	A psychologically safe meeting with those involved to summarise a critical event, hear from those affected and identify immediate learning. These are locally led events by skilled facilitators.
After Action Review (AAR)	2	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the those involved and can be used to discuss both positive outcomes as well as incidents.
Multidisciplinary Team review (MDT)	2	An MDT review supports care teams to learn from patient safety incidents that have occurred. the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion, systems analysis and other techniques to understand 'work as done', to agree the key contributory factors and system gaps that impact on safe patient care. These can be useful to learn from clusters of similar events.
Learning and Innovation From Events (LIFE) session	2	LIFE sessions aim to take stories/accounts from everyday events and incidents and promote discussions that help people to use these stories/accounts as a prompt to collaboratively talk about what stood out for them, what there is to celebrate, what we are curious about and what are the ideals and practical ideas that can be taken forward to benefit those who live, work in or visit the care setting. LIFE sessions adopt a relational approach to learning and improvement, as they create space for multiple perspectives to be heard. LIFE sessions can be used to discuss stories/accounts from patients, family members or staff.
Rapid Review	4	A simple locally led review based upon national criteria. This determines whether the incident requires a level 1 or 2 learning response or can be closed. These are reviewed weekly at the local triage meetings.

Other level 2 response types can be considered such as audit, table top exercises, observational studies, and local learning forums.

Appendix 4 – MKUH Patient Safety Priorities

Sepsis in the Emergency Department	Delay, or failure, to recognise and manage any adult patient presenting to the Emergency Department with signs of sepsis.
Surgical Inpatients	Delay, or failure, to recognise the deteriorating surgical patient resulting in: • Change of lead speciality team • Unexpected further surgery • Unplanned admission to ICU • Death Adult patients under surgical specialities or inpatients on wards 20, 21, 23 or 24.
Diagnostics Delays	Incidents relating to diagnosis, specifically delay or failure to follow up on abnormal scan/test results resulting in: • Unexpected progression or worsening of disease • Delay in surgical intervention • Need for additional tests or procedure
Inpatient Diabetes	Incidents relating to the prescribing and administration of insulin resulting in a patient's blood glucose of >20 mmol/l (on two consecutive readings) or < 4 mmol/l. Adult patient under acute medical care (ED, Ward 1 and ward 2)

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Meeting Title	**Trust Board (PUBLIC)**	**Date: 05 September 2024**
Report Title	MATERNITY VERBAL UPDATE	**Agenda Item Number: 9**
Lead Director	Dr Ian Reckless, CMO & Deputy Chief Executive	
Report Author	Fiona Hoskins Chief Nursing Officer	

Introduction	*Maternity Assurance Group (MAG) met on the 25th July 2024. The minutes from the group have not completed the pre-Board Governance cycle and are therefore not available to be presented.* *The July meeting followed the standard agenda as set out in the terms of reference, the group was quorate with attendance from Trust Maternity Champions and core maternity staff.*		
Key Messages to Note	*Verbal Update to include:* • *Maternity Incentive Scheme / CNST* • *CQC Update*		
Recommendation *(Tick the relevant box(es))*	**For Information** [x]	**For Approval** [ ]	**For Assurance** [ ]

Strategic Objectives Links	1. *Keeping you safe in our hospital* 2. *Improving your experience of care* 3. *Ensuring you get the most effective treatment* 4. *Giving you access to timely care*

Report History	
Next Steps	
Appendices/Attachments	

Glossary of Acronym

Acronyms	
CNST	Clinical Negligence Scheme for Trusts
MIS	Maternity Incentive Scheme

Meeting Title	TRUST BOARD (PUBLIC)	Date: 5 September 2024
Report Title	2024-25 Executive Summary M3	Agenda Item Number: 10
Lead Director	John Blakesley, Deputy CEO	
Report Author	Information Team	

Introduction	Purpose of the report: Standing Agenda Item

Key Messages to Note	**Emergency Department:**
	- There were 8,954 ED attendances in July 2024, a decrease of 60 attendances when compared to June 2024.
	- The percentage of attendances admitted, transferred, or discharged within 4 hours was 75.1%, an improvement compared to 70.9% in June 2024.
	- 81.5% of ambulance handovers took less than 30 minutes in July 2024 and 97.8% took less than 60 minutes.
	
	Outpatient Transformation:
	- There were 40,810 outpatient attendances in July 2024.
	- 11.6% of these appointments were attended virtually and 7.2% of patients did not attend.
	
	Elective Recovery:
	- There were 2,468 elective spells in July 2024.
	- At the end of July 2024, 36,040 patients were on an open RTT pathway:
	  ○ 1,132 patients were waiting more than 65 weeks.
	  ○ 62 patients were waiting over 78 weeks.
	- At the end of July 2024, 12,973 patients were waiting for a diagnostic test. Of these, 57.4% were waiting less than 6 weeks.
	
	Inpatients:
	- Overnight bed occupancy in adult G&A beds was 91.2% in July 2024.
	- A considerable proportion of beds were unavailable due to:
	  ○ 123 super stranded patients (length of stay 21 days or more).
	
	Human Resources:
	- In June 2024:
	  ○ Substantive staff turnover was 12.5%.
	  ○ Agency expenditure remained well below the threshold of 5%, at 3.6%.
	  ○ Appraisals was 91% and mandatory training was 94%.
	
	Patient Safety:
	- In June 2024, the following infections were reported:
	  ○ C.Diff: 4
	  ○ E-Coli: 1
	  ○ Kilebsiella Spp bacteraemia: 1
	  ○ MRSA: 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: M04 (July 2024)

1.0 Summary

This report summarises performance against key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance.

This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy. It is important to highlight that some local transitional or phased targets have been agreed to measure progress in recovering performance. It should however also be noted that NHS Constitutional Targets remain, as highlighted in the table below:

Indicator Description	Transitional Target	Constitutional Target
ED 4 hour target (includes UCS)	75.2%	95%
RTT Incomplete Pathways <18 weeks	92%	92%
RTT Patients waiting over 65 weeks	954	0
Diagnostic Waits <6 weeks	95%	99%

To ensure that the continued impact of COVID-19 is reflected, monthly trajectories are in place to ensure that they are reasonable and reflect a realistic level of recovery for the Trust to achieve.

2.0 Operational Performance Targets

July 2024 performance against transitional targets and recovery trajectories:

Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
ED 4 hour target (includes UCS)	78.2%	75.2%	73.3%	75.1%	×	▲	×	
RTT Incomplete Pathways <18 weeks	92.0%	92.0%		38.3%	×	▼		
RTT Patients waiting over 65 weeks (Total)	0	954		1,132	×	▲		
Diagnostic Waits <6 weeks	95.0%	95.0%		57.4%	×	▲		
62 day standard (Quarterly)	70.3%	65.6%		54.5%	×	▼		

The percentage of ED attendances that were admitted, transferred, or discharged within four hours was 75.1%, an improvement in performance compared to recent months. This was consistent with the national performance of 75.2% (see Appendix 1).

The volume of open RTT pathways was 36,040, a decrease of 53 compared to June 2024. Of this total, 1,132 patients had waited more than 65 weeks for treatment. The Trust has robust recovery plans in place to support an improvement in RTT performance and to reduce patient waiting times. The cancellation of non-urgent elective activity and treatment for patients on an incomplete RTT pathway is also being proactively managed.

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

In Q1 2024/25, the 62-day standard performance (from receipt of an urgent GP referral for suspected cancer to first treatment) was 54.5% against a national target of 85%, declining from 58.7% in the previous quarter. The percentage of patients to begin cancer treatment within 31 days of a decision to treat decreased from 95.2% to 94.5%, below the national target of 96%. The 28 Day Faster Diagnosis performance was 68.8%, down from 72.9% in the previous quarter.

3.0 Urgent and Emergency Care

During July 2024, two of the five key indicators saw a month-on-month improvement:

Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Cancelled Ops - On Day	1%	1%	0.34%	0.42%	✓	▼	✓	
Ward Discharges by Midday	25%	25%	17.3%	17.1%	✗	▲	✗	
Patients not meeting Criteria to Reside	50			106	✗	▼		
Number of Super Stranded Patients (LOS>=21 Days)	50			123	✗	▼		
Ambulance Handovers <60 mins (%)	100%	100%	96.5%	97.8%	✗	▲	✗	

Cancelled Operations on the Day

In July 2024, seven operations were cancelled on the day for non-clinical reasons. Cancellation reasons included insufficient time, surgeon being unwell or consultant not available.

Patients not Meeting Criteria to Reside

The number of inpatients not meeting the criteria to reside at the end of July 2024 was 106 against a threshold of 50. This was an increase compared to 95 reported last month.

Length of Stay (Stranded and Super Stranded Patients)

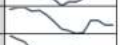
The number of super stranded patients (e.g. length of stay of 21 days or more) at the end of the month was 123. This was an increase compared to 109 reported in June 2024.

Ambulance Handovers

In July 2024, the percentage of ambulance handovers to the Emergency Department taking less than 30 minutes was 81.5%; an improvement in performance when compared with June 2024 (78.7%).

The percentage of ambulance handovers to the Emergency Department taking less than 60 minutes was 97.8%; an improvement in performance compared to 96.8% in the previous month.

4.0 Elective Pathways

Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Overnight Bed Occupancy - Adult G&A	95.4%	96.0%	92.6%	91.2%	✓	▲	✓	
RTT Incomplete Pathways <18 weeks	92.0%	92.0%		38.3%	✗	▼		
RTT Total Open Pathways (inluding ASIs)	32,549	34,311		36,040	✗	▲		
Diagnostic Waits <6 weeks	95.0%	95.0%		57.4%	✗	▲		

Overnight Bed Occupancy

Overnight bed occupancy decreased to 91.2% during July 2024 from 94.2% in June 2024.

RTT Incomplete Pathways

The Trust's Incomplete Pathways <18 weeks at the end of July 2024 was 38.3% and the number of patients waiting over 65 weeks was 1,132. Total RTT open pathways was 36,040.

Diagnostic Waits <6 weeks

At the end of July 2024, performance was 57.4% an improvement compared with 56.1% in June 2024.

5.0 Patient Safety

Infection Control

In June 2024, the following infections were reported:

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

May 2024 to July 2024 ED Performance Ranking

MKUH Peer Group Comparison - ED Performance	May-24	June-24	July-24
Homerton Healthcare NHS Foundation Trust	80.0%	82.1%	86.9%
Oxford University Hospitals NHS Foundation Trust	74.9%	74.0%	78.7%
Milton Keynes University Hospital NHS Foundation Trust	73.3%	70.9%	75.1%
Northampton General Hospital NHS Trust	72.7%	72.9%	75.0%
Mersey and West Lancashire Teaching Hospital NHS Trust (Formerly Southport and Ormskirk)	68.2%	72.6%	74.5%
Buckinghamshire Healthcare NHS Trust	72.9%	74.5%	72.6%
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	73.4%	71.8%	71.9%
The Hillingdon Hospitals NHS Foundation Trust	75.8%	71.0%	71.6%
Barnsley Hospital NHS Foundation Trust	71.0%	73.2%	71.4%
North Middlesex University Hospital NHS Trust	63.9%	64.8%	68.4%
Mid Cheshire Hospitals NHS Foundation Trust	58.8%	59.2%	63.4%
The Princess Alexandra Hospital NHS Trust	64.1%	61.4%	63.0%

Board Performance Report 2024/25
July 2024 (M04)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Mortality - (HSMR) ★		91.0	91.0		90.9	✓	▲		
Mortality - (SHMI)		100.0	100.0		110.3	✗	▼		
Never Events		0	0	0	0	✓	▬	✓	
Clostridium Difficile		20	7	12	4	✗	▼	✗	
MRSA bacteraemia (avoidable)		0	0	1	1	✗	▼	✗	
Falls with harm (per 1,000 bed days)		0.12	0.12	0.14	0.07	✓	▲	✓	
Incident Rate (per 1,000 bed days)		60	60	54.01	57.13	✗	▲	✗	
Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
E-Coli		27	9	6	1	✓	▲	✓	
MSSA		17	<6	2	0	✓	▬	✓	
VTE Assessment		95%	95%	97.2%	97.0%	✓	▼	✓	
Klebsiella Spp bacteraemia		14	<5	8	1	✓	▲	✗	
P.aeruginosa bacteraemia		9	3	1	0	✓	▲	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
RED Complaints Received		0	0	0	0	✓	▬	✓	
Formal Complaints responded in agreed time		90%	90%	70.4%	50.0%	✗	▼	✗	
Cancelled Ops - On Day		1%	1%	0.34%	0.42%	✓	▼	✓	
Over 75s Ward Moves at Night		1,500	500	541	122	✓	▲	✗	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Overnight Bed Occupancy - Adult G&A		95.4%	96.0%	92.6%	91.2%	✓	▲	✓	
Ward Discharges by Midday		25%	25%	17.3%	17.1%	✗	▲	✗	
Weekend Discharges		63%	63%	60.9%	59.4%	✗	▼	✗	
Patients not meeting Criteria to Reside		50			106	✗	▼		
Number of Stranded Patients (LOS>=7 Days)		184			282	✗	▼		
Number of Super Stranded Patients (LOS>=21 Days)		50			123	✗	▼		
Discharges from PDU (%)		12.5%	12.5%	10.9%	10.2%	✗	▼	✗	
Ambulance Handovers <30 mins (%)		95%	95%	78.5%	81.5%	✗	▲	✗	
Ambulance Handovers <60 mins (%)		100%	100%	96.5%	97.8%	✗	▲	✗	

OBJECTIVE 4 - KEY TARGETS									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
ED 4 hour target (includes UCS)		78.2%	75.2%	73.3%	75.1%	✗	▲	✗	
Total time in ED no more than 12 hours		95%	95%	94.6%	96.8%	✓	▲	✗	
Triage within 15 Minutes		90%	90%	69.0%	71.1%	✗	▲	✗	
RTT Incomplete Pathways <18 weeks		92.0%	92.0%		38.3%	✗	▼		
RTT Total Open Pathways (inluding ASIs)		32,549	34,311		36,040	✗	▲		
Open AFBs					2,652		▲		
Referrals Waiting for Triage					2,848		▲		
RTT Patients waiting over 65 weeks (Total)		0	954		1,132	✗	▲		
RTT Patients waiting over 65 weeks - Non-Admitted					718				
RTT Patients waiting over 65 weeks - Admitted					414				
RTT Patients waiting over 78 weeks (Total)		0	0		62	✗			
Diagnostic Waits <6 weeks		95.0%	95.0%		57.4%	✗	▲		
31 days Diagnosis to Treatment (Quarterly)		96.0%	96.0%		94.5%	✗	▼		
62 day standard (Quarterly)		70.3%	65.6%		54.5%	✗	▼		
28 Day Faster Diagnosis (Quarterly)		78.0%	75.0%		68.8%	✗	▼		

OBJECTIVE 5 - SUSTAINABILITY									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Total Referrals Received		Not Available		66,935	15,553	Not Available	▼	Not Available	
Total ASIs		0	0		1,921	✗	▲		
Total RTT Non-Admitted Open Pathways					30,385		▲		
Total RTT Admitted Open Pathways					5,655		▲		
A&E Attendances		101,918	33,825	35,417	8,918	✗	▲	✗	
Elective Spells		26,032	8,097	9,741	2,468	✓	▲	✓	
Non-Elective Spells		28,831	9,368	10,153	2,558	✗	▲	✗	
OP Attendances / Procs (Total)		443,414	143,378	159,886	40,810	✓	▼	✓	
Outpatient DNA Rate		5%	5%	7.3%	7.2%	✗	▲	✗	
Virtual Outpatient Activity		25%	25%	12.6%	11.6%	✗	▼	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Income £'000		393,248	128,999	130,810	33,509	✓	▲	✓	
Pay £'000		(246,892)	(82,565)	(84,980)	(21,179)	✗	▲	✗	
Non-pay £'000		(115,359)	(41,754)	(42,261)	(11,097)	✗	▼	✗	
Non-operating costs £'000		(30,997)	(8,522)	(7,849)	(1,966)	✓	▼	✓	
I&E Total £'000		0	(3,842)	(4,279)	(733)	✓	▲	✗	
Cash Balance £'000			26,032		17,474	✗	▲		
Savings Delivered £'000		23,822	7,940	3,659	1,812	✗	▲	✗	
Capital Expenditure £'000		(28,670)	(8,351)	(6,496)	(2,600)	✗	▼	✗	
Elective Spells (% of 2019/20 performance)		130%	130%	115.5%	110.5%	✗	▼	✗	
OP Attendances (% of 2019/20 performance)		130%	130%	112.7%	112.2%	✗	▼	✗	

OBJECTIVE 8 - WORKFORCE PERFORMANCE									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Staff Vacancies % of establishment		7.5%	7.5%		6.0%	✓	▲		
Agency Expenditure %		5.0%	5.0%	3.7%	3.6%	✓	▲	✓	
Staff Sickness % - Days Lost (Rolling 12 months)		5.0%	5.0%		4.8%	✓	▬		
Appraisals (excluding doctors)		90%	90%		91.0%	✓	▬		
Statutory Mandatory training		90%	90%		94.0%	✓	▼		
Substantive Staff Turnover		12.5%	12.5%		12.5%	✓	▲		

OBJECTIVES - OTHER									
Indicator	DQ Assurance	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Total Number of NICE Breaches		8	8		0	✓	▲		
Rebooked cancelled OPs - 28 day rule		90%	90%	90.2%	100.0%	✓	▲	✓	
Overdue Incidents >1 month		Not Available			248		▲		
Serious Incidents		40	14	6	3	✓	▼	✓	

Key: Monthly/Quarterly Change

▲	Improvement in monthly / quarterly performance
▬	Monthly performance remains constant
▼	Deterioration in monthly / quarterly performance
	NHS Improvement target (as represented in the ID columns)
	Reported one month/quarter in arrears

YTD Position

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

Data Quality Assurance Definitions

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

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

Board Performance Report: M04 (July 2024)

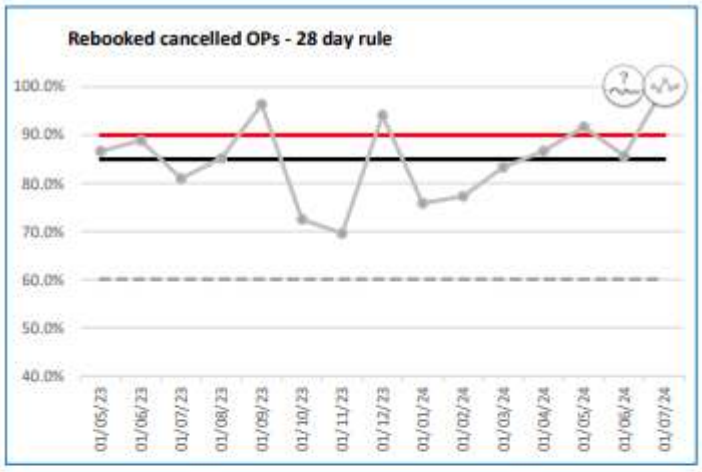
OBJECTIVE O - OTHER

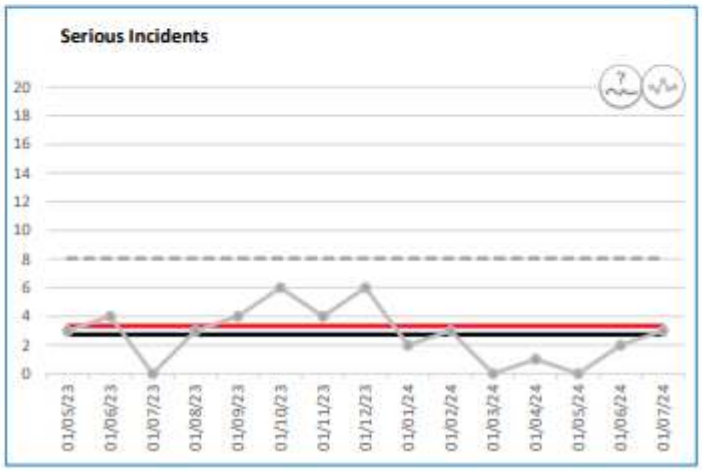
July 2024 and YTD performance against transitional targets and recovery trajectories:

OBJECTIVES - OTHER								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Rebooked cancelled OPs - 28 day rule	90%	90%	90.2%	100.0%	✓	▲	✓	
Serious Incidents	40	14	6	3	✓	▼	✓	

Key Points

- **Rebooked Cancelled Ops within 28 Days:** Of the seven operations cancelled on the day for non-clinical reasons, 100% were rebooked within 28 days. This has demonstrated an improvement since March.
- **Serious Incidents** This remained within common cause variation.





Threshold
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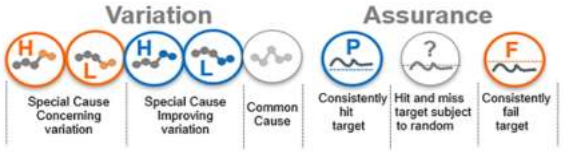


Board Performance Report: M04 (July 2024)

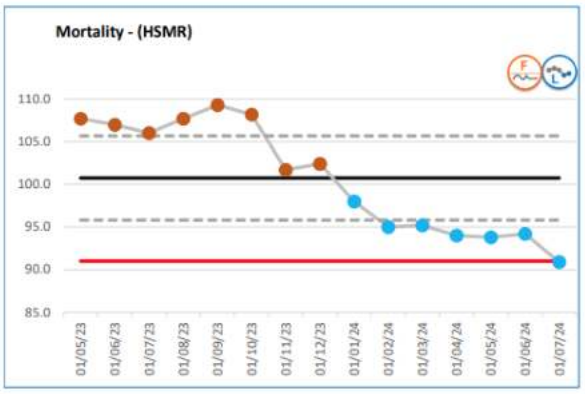
OBJECTIVE 1 – PATIENT SAFETY

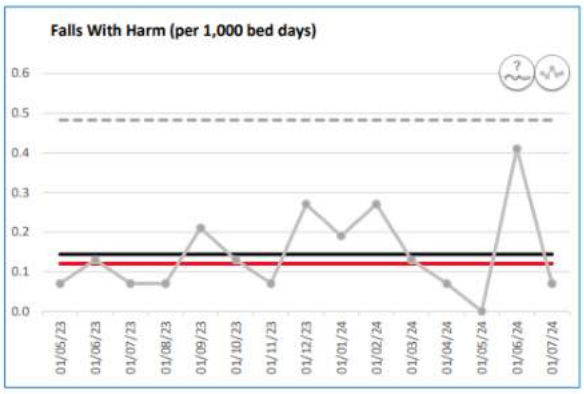
July 2024 and YTD performance against targets and thresholds:

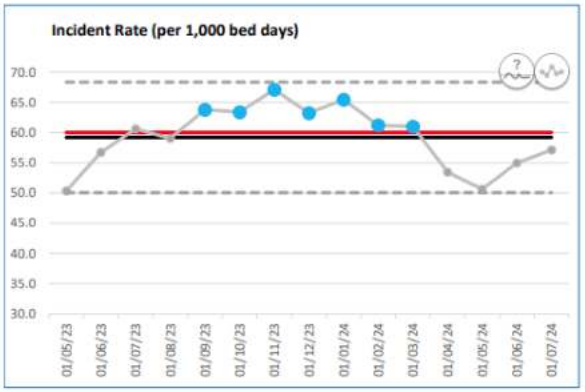
OBJECTIVE 1 - PATIENT SAFETY								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Mortality - (HSMR) ★	91.0	91.0		90.9	✓	▲		
Falls with harm (per 1,000 bed days)	0.12	0.12	0.14	0.07	✓	▲	✓	
Incident Rate (per 1,000 bed days)	60	60	54.01	57.13	✗	▲	✗	
VTE Assessment	95%	95%	97.2%	97.0%	✓	▼	✓	

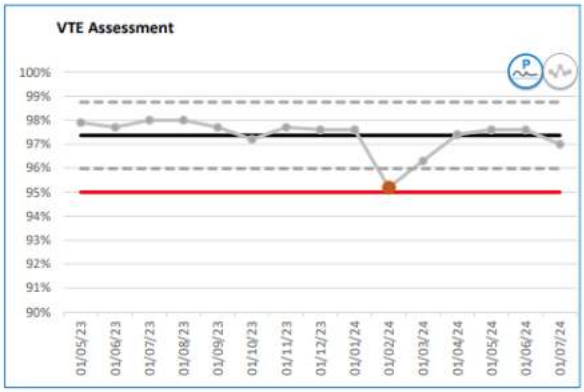
Key Points

- **HSMR:** This metric shows special cause improvement, with a continued steep decline from 109.3 in September 2023 to 90.9 in July 2024, remaining below the national peer figure of 91.
- **Falls with Harm:** The metric has again fallen below the threshold, with 0.1 reported falls per 1,000 bed days in July 2024, an improvement from 0.41 in June 2024.
- **Incident Rate:** The incident reporting rate has remained below the threshold for the fourth consecutive month.
- **VTE Assessment:** This metric shows common cause variation, consistently staying above the threshold of 95%.

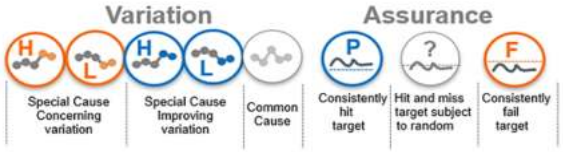








Threshold
Mean



Board Performance Report: M04 (July 2024)

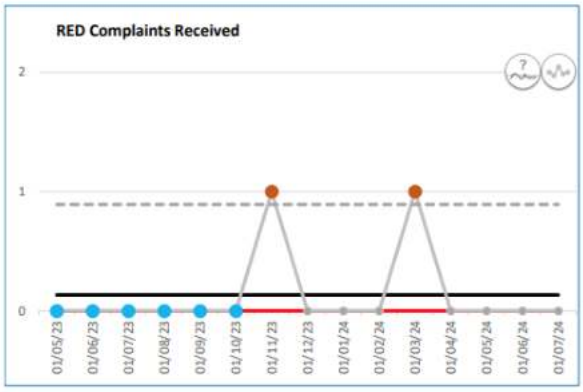
OBJECTIVE 2 – PATIENT EXPERIENCE

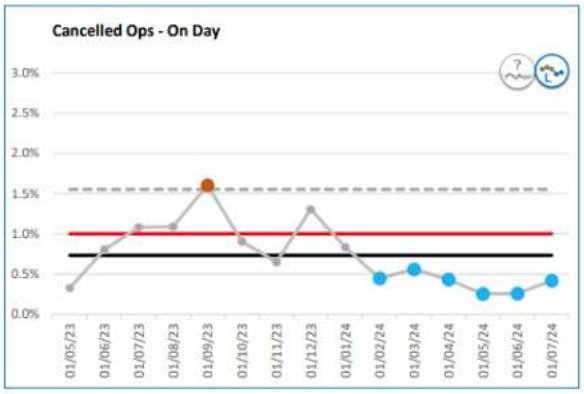
July 2024 and YTD performance against targets and thresholds

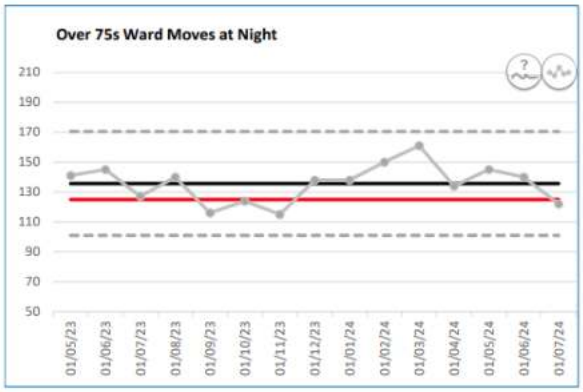
OBJECTIVE 2 - PATIENT EXPERIENCE								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
RED Complaints Received	0	0	0	0	✓	–	✓	
Cancelled Ops - On Day	1%	1%	0.34%	0.42%	✓	▼	✓	
Over 75s Ward Moves at Night	1,500	500	541	122	✓	▲	✗	

Key Points

- **RED Complaints Received:** No RED complaints were reported in July 2024.
- **Operations cancelled on the Day:** This metric demonstrates improving variation and has remained below the threshold for the past six months.
- **Over 75s Ward Moves at Night**: While staying within expected variation, this metric demonstrated improved performance by dropping below the agreed threshold to 122 in July 2024, the first such occurrence since November 2023.







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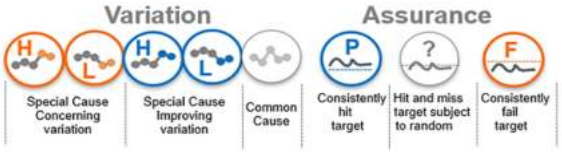


Board Performance Report: M04 (July 2024)

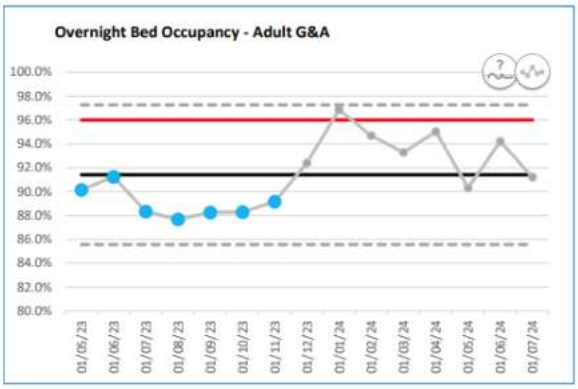
OBJECTIVE 3 – CLINICAL EFFECTIVENESS

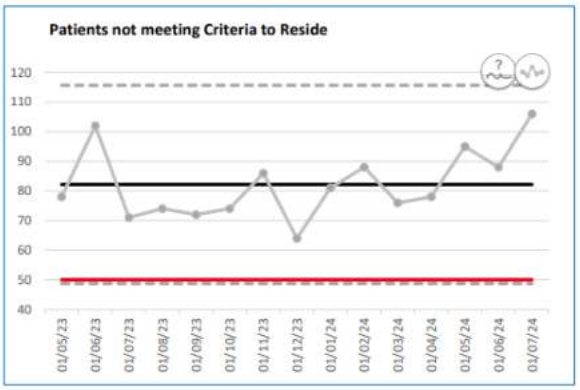
July 2024 and YTD performance against transitional targets and recovery trajectories:

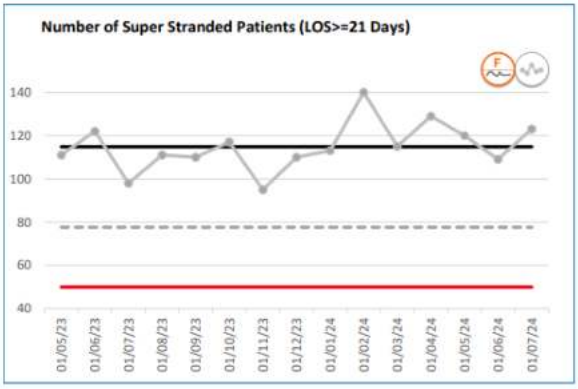
OBJECTIVE 3 - CLINICAL EFFECTIVENESS								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Overnight Bed Occupancy - Adult G&A	95.4%	96.0%	91.9%	88.2%	✓	▲	✓	
Patients not meeting Criteria to Reside	50			106	x	▼		
Number of Super Stranded Patients (LOS>=21 Days)	50			123	x	▼		
Ambulance Handovers <30 mins (%)	95%	95%	78.5%	81.5%	x	▲	x	

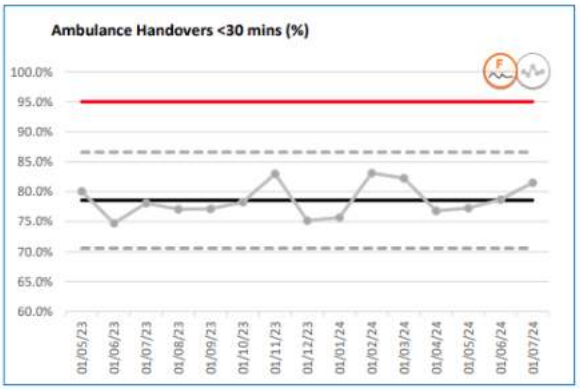
Key Points

- **Overnight Bed Occupancy:** This metric shows common cause variation, with occupancy at 91.9% in July 2024, down from a high of 96.9% in January 2024.
- **Patients not meeting Criteria to Reside**: This metric is within common cause variation but has consistently remained higher than the agreed threshold of 50.
- A significant number of beds were unavailable due to:
  - 123 super stranded patients (length of stay 21 days or more).
  - 282 stranded patients (length of stay 7 days or more)
- **Ambulance Handovers:** This metric consistently falls short of the target but stays within the upper and lower control limits. Performance was at 81.5% in July 2024, against a 95% threshold.









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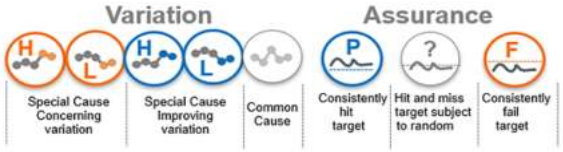


TheMKWay

NHS Milton Keynes University Hospital NHS Foundation Trust

Board Performance Report: M04 (July 2024)

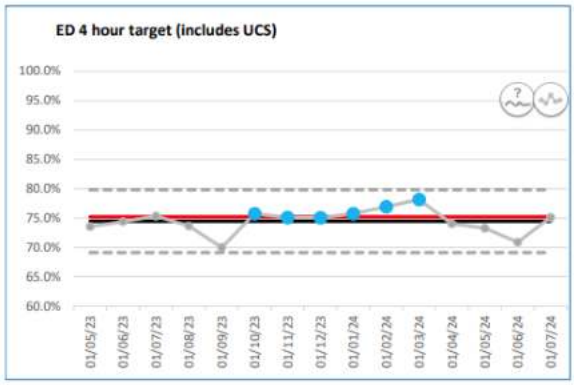
OBJECTIVE 4 - KEY TARGETS

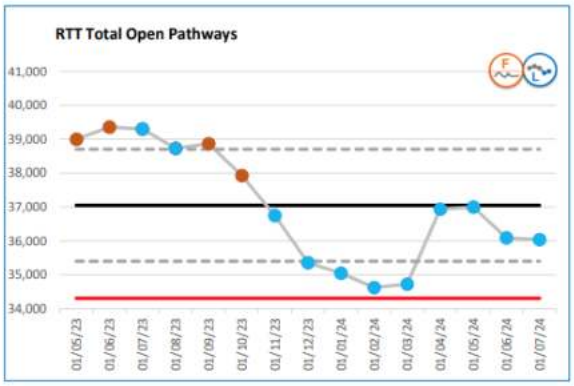
July 2024 and YTD performance against transitional targets and recovery trajectories:

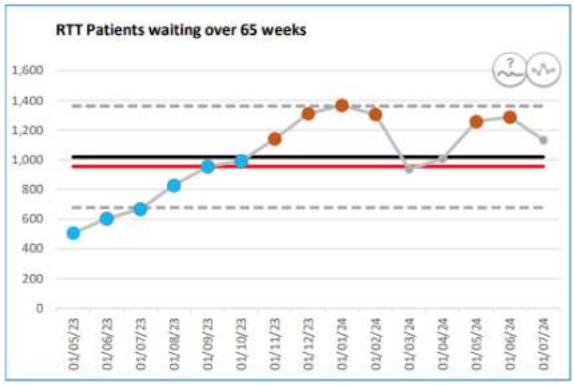
OBJECTIVE 4 - KEY TARGETS								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
ED 4 hour target (includes UCS)	78.2%	75.2%	73.3%	75.1%	×	▲	×	
RTT Total Open Pathways (inluding ASIs)	32,549	34,311		36,040	×	▲		
RTT Patients waiting over 65 weeks (Total)	0	954		1,132	×	▲		
Diagnostic Waits <6 weeks	95.0%	95.0%		57.4%	×	▲		

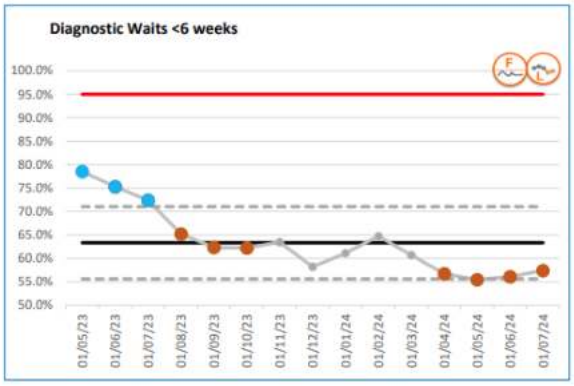
Key Points

- **ED 4-hour Performance:** In July 2024, performance was consistent with the revised 75.2% threshold at 75.1%. This was an improvement on 70.9% in June 2024.
- **RTT Open Pathways:** There were 36,040 patients on an open RTT pathway, exceeding the operational plan for July 2024. However, a reduction over the past month indicates improving variation, reflecting the impact of the recovery plan. Among these patients:
  - 1,132 patients had been waiting over 65 weeks.
  - 62 patients had been waiting over 78 weeks.
- **RTT Patients waiting Over 65 Weeks:** Of the 1,132 patients
  - 718 patients were on the non-admitted waiting list.
  - 414 patients were on the Admitted waiting list.
- **Diagnostics**: A total of 12,973 patients were waiting for a diagnostic test, with 57.4% waiting less than 6 weeks. This metric shows special cause variation and has consistently been below the threshold.









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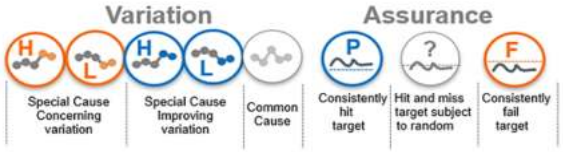


Board Performance Report: M04 (July 2024)

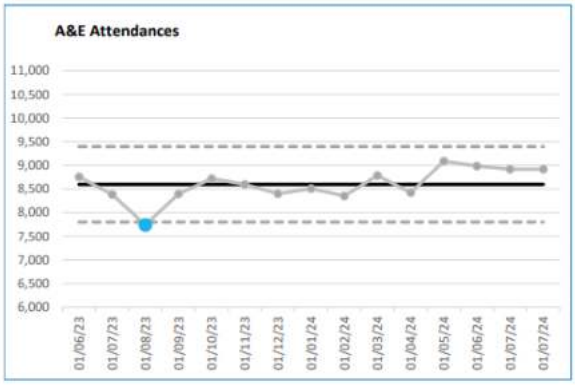
OBJECTIVE 5 – SUSTAINABILITY

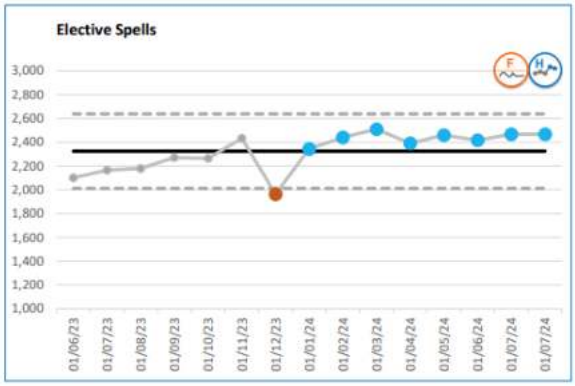
July 2024 and YTD performance against transitional targets and recovery trajectories:

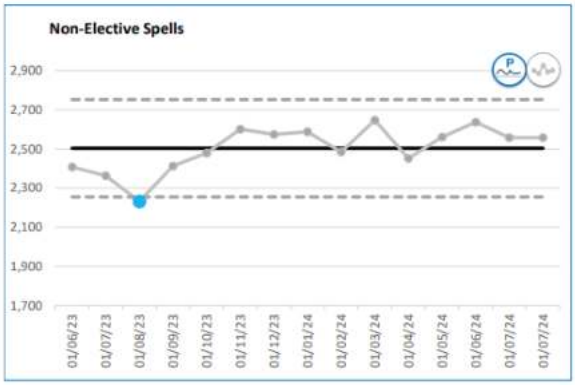
OBJECTIVE 5 - SUSTAINABILITY								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
A&E Attendances	101,918	33,825	35,417	8,918	✗	▲	✗	
Elective Spells	26,032	8,097	9,741	2,468	✓	▲	✓	
Non-Elective Spells	28,831	9,368	10,153	2,558	✗	▲	✗	
OP Attendances / Procs (Total)	443,414	143,378	159,886	40,810	✓	▼	✓	
Outpatient DNA Rate	5%	5%	7.3%	7.2%	✗	▲	✗	

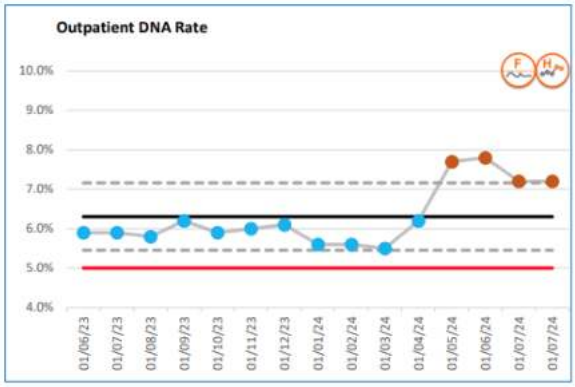
Key Points

- **A&E Attendances:** There were 8,918 A&E attendances in July 2024. This was above the activity plan for the month by 357.
- **Elective Spells:** This is showing special cause improving variation.
- **Non-Elective Spells:** This is consistently higher than planned.
- **Outpatient DNA Rate:** 7.3% of patients did not attend their appointment in July 2024. This has been above the upper control limit since May 2024 and is demonstrating special cause concerning variation.









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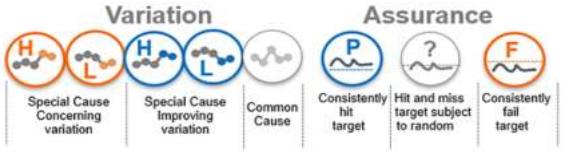


Board Performance Report: M04 (July 2024)

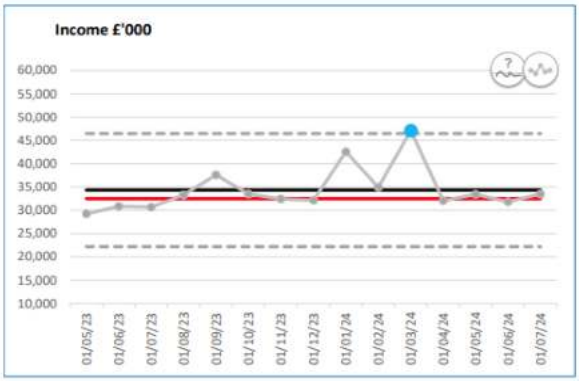
OBJECTIVE 7 - FINANCIAL PEFORMANCE

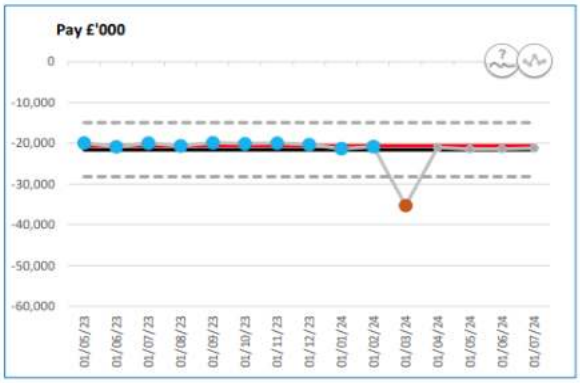
July 2024 and YTD performance against transitional targets and recovery trajectories:

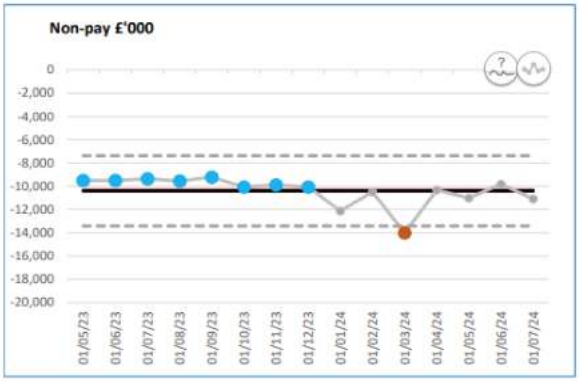
OBJECTIVE 7 - FINANCIAL PERFORMANCE								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Income £'000	393,248	128,999	130,810	33,509	✓	▲	✓	
Pay £'000	(246,892)	(82,565)	(84,980)	(21,179)	×	▲	×	
Non-pay £'000	(115,359)	(41,754)	(42,261)	(11,097)	×	▼	×	
Non-operating costs £'000	(30,997)	(8,522)	(7,849)	(1,966)	✓	▼	✓	

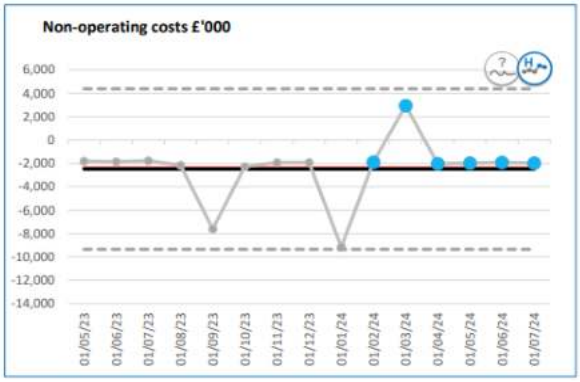
Key Points

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









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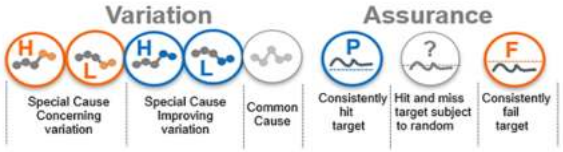


Board Performance Report: M04 (July 2024)

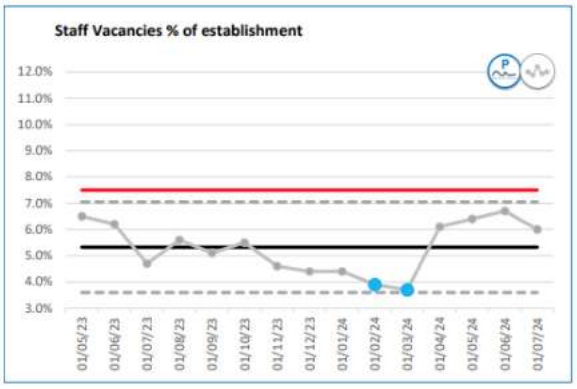
OBJECTIVE 8 - WORKFORCE PEFORMANCE

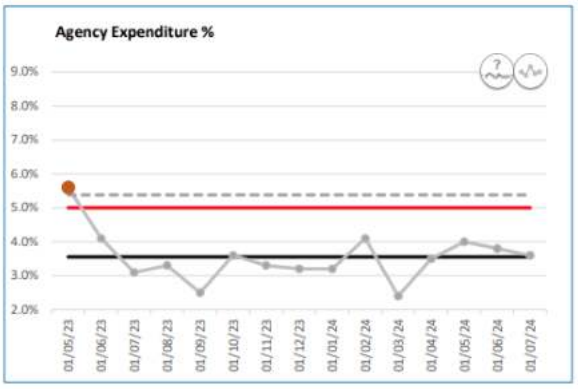
July 2024 and YTD performance against transitional targets and recovery trajectories:

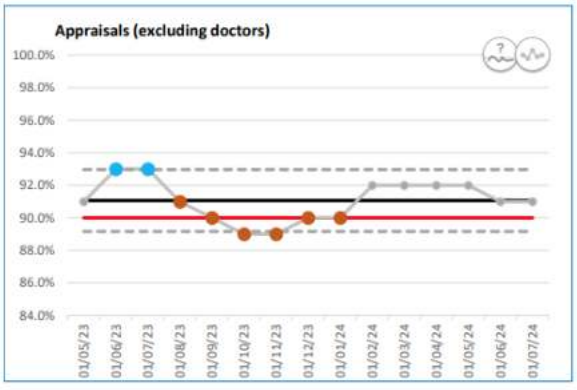
OBJECTIVE 8 - WORKFORCE PERFORMANCE								
Indicator	Threshold 2024-25	Month/YTD Threshold	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
Staff Vacancies % of establishment	7.5%	7.5%		6.0%	✓	▲		
Agency Expenditure %	5.0%	5.0%	3.7%	3.6%	✓	▲	✓	
Appraisals (excluding doctors)	90%	90%		91.0%	✓	▬		
Statutory Mandatory training	90%	90%		94.0%	✓	▼		

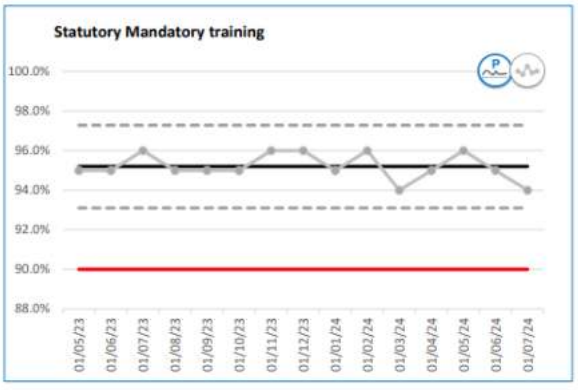
Key Points

- **Staff Vacancies:** The staff vacancy rate was reported at 6.0% in July 2024, continuing below the agreed 7.5% threshold.
- **Agency Expenditure:** July 2024 remained within common cause variation and has been below the 5% threshold for the past 14 months.
- **Appraisals:** This remained at 91% and within common cause variation.
- **Statutory Mandatory Training:** This declined slightly to 94% in July 2024 but has been consistently above the 90% target.









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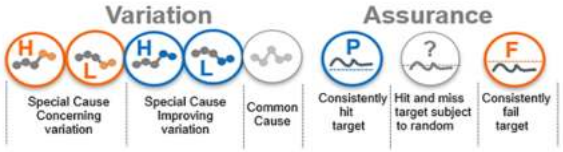


Meeting Title	**Public Board**	**Date: 5 September 2024**
Report Title	**Finance Paper Month 4 2024-25**	**Agenda Item Number: 11**
Lead Director	**Jonathan Dunk**	**Chief Finance Officer**
Report Authors	**Sue Fox** **Cheryl Williams**	**Head of Financial Management** **Head of Financial Control and Capital**

Introduction	This report provides an update on the financial position of the Trust at Month 4 (July 2024).		
Key Messages to Note	The Trust is reporting a deficit position of £4.3m (on a Control Total basis) to the end of the July, which is adverse to plan by £0.4m. However, Month 4 saw a favourable in month variance to plan of £0.2m Elective Recovery Fund (ERF) performance is currently above the 106% target, with income showing £5.6m above the national target as at M04. resulting in a favourable income variance to plan of £1.9m. The Trust has a challenging financial plan this year which includes a savings target of 6% (£23.8m). £3.6m has been achieved to date against a year-to-date plan of £7.9m.		
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	To note the contents of this report.
Appendices	Pages 10-12

FINANCE REPORT FOR THE MONTH TO 31st JULY 2024

TRUST BOARD

CONTENTS

TheMKWay

NHS
Milton Keynes University Hospital
NHS Foundation Trust

EXECUTIVE SUMMARY

Ref	All Figures in £'000	In Month Plan	In Month Actual	In Month Var	YTD Plan	YTD Actual	YTD Var	Full Year Plan	Full Year Forecast	Full Year Var	RAG
1	Clinical Revenue	30,038	31,440	1,402	120,001	122,185	2,184	361,218	361,218	-	
2	Other Revenue	1,775	1,689	(87)	8,838	13,633	4,795	31,662	31,662	-	
3	Pay	(20,314)	(21,179)	(865)	(82,618)	(84,980)	(2,362)	(247,157)	(247,157)	-	
4	Non Pay	(10,451)	(11,097)	(645)	(41,702)	(42,261)	(559)	(115,206)	(115,206)	-	
5	Financing & Non-Ops	(2,071)	(2,017)	54	(8,206)	(8,052)	154	(24,931)	(24,931)	-	
6	Surplus/(Deficit)	(1,023)	(1,164)	(141)	(3,686)	525	4,212	5,586	5,586	-	
7	Control Total Surplus/(Deficit)	(965)	(733)	232	(3,842)	(4,280)	(437)	-	-	-	
	Memos										
8	IA Cost	-	-	-	-	(153)	(153)	-	(153)	(153)	
9	High Cost Drugs	(2,048)	(2,767)	(719)	(8,375)	(9,651)	(1,276)	(25,351)	(25,351)	-	
10	Financial Efficiency	1,985	1,812	(173)	7,941	3,659	(4,282)	23,822	23,822	-	
11	Cash	22,451	17,474	(4,977)	22,451	17,474	(4,977)	12,356	12,356	-	
12	Capital Plan including donated	(2,999)	(2,600)	399	(6,722)	(6,496)	226	(38,670)	(38,010)	660	

Key messages

The Trust is reporting a deficit position of £4.3m (on a Control Total basis) to the end of July 2024. This is worse than plan by £0.4m but in month we have seen a favourable variance to plan of £0.2m and an improvement in the actual month run-rate position of £0.5m.

At month 4 the Trust is behind its savings plan by £4.3m which is reflected in the pressure on the expenditure budgets.

ERF performance is currently above the 106% target, with income showing £5.6m above the national target as at M04 and £1.9m favourable to Plan. There is a risk relating to SDEC coding which would impact the ERF position in the second half of the financial year unless we take mitigating action.

The capital expenditure programme is close to plan and it is expected to be slightly below plan by the end of the year to align with the approved CDEL allocation

(1 & 2.) Revenue – Clinical revenue for Integrated Care Board (ICB), NHS England (NHSE) contracts, and variable (non-ICB income) is above plan, due to Elective Recovery Fund (ERF) and the high-cost drugs (HCD) over performance. Other revenue is above plan due principally to donated income received.

(3. & 4.) Operating expenses – Pay costs are higher than plan due to the cost of temporary staff in escalation wards and additional hours carried out to reduce elective backlogs. Agency expenditure has reduced slightly in July and is partly offset by substantive vacancies. Non-pay is overspent with an overspend on drugs offset by income for high-cost drugs.

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

(8.) Industrial Action costs – there was 1 day of industrial action in July but these costs were reflected in the month 3 position.

(10.) Financial Efficiency – £3.6m delivered YTD against an annual target of £23.8m. This reflects in-month delivery of £1.8m.

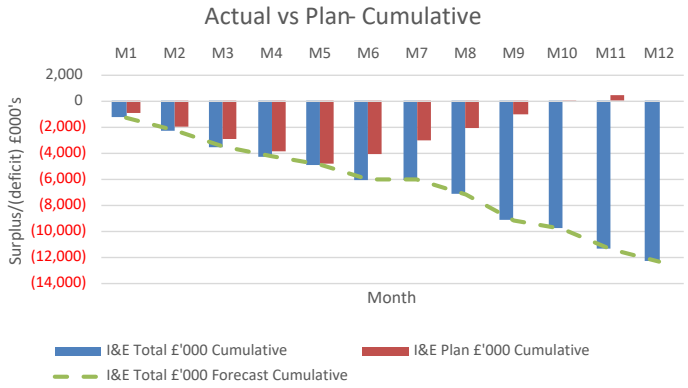
(11.) Cash – Cash balance is £17.5m, equivalent to 17 days cash to cover operating expenses.

(12.) Capital – Capital expenditure is slightly above plan YTD due to the timing of capital schemes. However, the Trust is expected to be marginally below its year end plan as it has aligned its year end forecast position to the approved CDEL allocation which is £0.6m lower that the trusts plan. The Trust has now received a letter of approval from the Joint Investment Sub-committee for the NHP enabling scheme for the Imaging Centre and are now awaiting the funding forms approved by the Secretary of State.

FORECAST

2. Forecast

The annual plan for 2024/25 is for a breakeven position. The phasing of the final submitted plan delivers a deficit in the first 5 months of the year, followed by a surplus in the remaining months, to arrive at breakeven by March 2025. See the graph below for monthly phasing of plan against draft forecast:



The Trust continues to forecast a breakeven position in line with plan. However, there are very clear risks to delivery of this, including the need to recover the adverse year to date position, need to ensure payment of additional ERF income, costs of approved RTT recovery investments, additional cost pressures from utility costs and, more generically, the risk of full delivery of planned efficiency savings. As would be expected, the Trust is ensuring all possible options to mitigate against these risks, and ensure plan delivery, are explored.

3. Risks to Plan Achievement

Industrial action cost and lost income, ongoing cost of escalation capacity, cost pressures from RTT recovery, winter pressures, financial efficiency slippage, ERF baseline adjustments, the impact of Emergency Data Set reporting changes on ERF achievement.

4. Opportunities to improve the Position

ERF income for additional elective work, marginal funding for premium elements of RTT plans, baseline adjustment for SDEC, recovery from community providers for delayed discharges and non-recurrent plan mitigation.

Key message

The YTD position, and identified risks for the rest of the financial year, show clearly that delivery of the planned position will remain challenging. Work will continue to progress any mitigations necessary to reach breakeven. Achievement of the plan will depend heavily on the required efficiency savings being realised and the run rate steadily improving in the second half of the financial year, as well as achieving additional ERF income to offset investment in RTT recovery.

CLINICAL INCOME

5. Block contracts.

The Trust block contracts historically make up around 88% of the total clinical income, covering all activity except for planned care (covered by ERF), diagnostic imaging, HCD and devices, specialised chemotherapy activity, and the Community Diagnostic Centre (CDC).

6. Elective Recovery Fund (ERF).

Planned care income is managed through the ERF scheme. The 2024/25 target for MKUH is 106% above 2019/20 values. In 2023/24 the ERF target was reduced by 4% to 102% to compensate for the industrial action, but this has now been restored to the original target.
The reported position reflects the nationally published 2024/25 baseline values, which include a working day (WD) adjustment to account for the number of additional days in 2024/25 compared to 2023/24. This resulted in a material increase to the baseline (c£1.2m).

The July (M04) ERF position shows an estimated income from over-performance against the 106% target of £5.6m. Including advice and guidance, the combined ERF performance shows £6.3m earned year to date. The 2024/25 values are higher than at this point of 2023/24. Using indicative data and the nationally reported ERF rules, below shows the Trust M04 performance by care type.

	YTD Financial performance					YTD Activity performance				Current year (YTD) vs Prior Year (YTD)		
Care Type	2024/25 Target	YTD National Baseline (£) incl 106% Stretch	YTD actuals	YTD Variance	YTD Performance compared to 2019/20 (%)	YTD Target activity incl 106% Stretch	YTD actuals	YTD Variance	YTD Performance compared to 2019/20 (%)	Prior year YTD (£)	Current year YTD (£)	Variance (£)
01_Elective Day Case	98%	£5,675,099	£7,171,876	£1,496,777	133.30%	5,680	8,606	2,926	148.48%	£6,017,717	£7,171,876	£1,154,159
02_Elective Inpatient	102%	£4,489,247	£4,689,757	£200,510	110.19%	1,164	1,622	458	142.16%	£3,824,702	£4,689,757	£865,055
03_First Attendance with Procedure	110%	£1,286,700	£1,188,179	-£98,521	97.40%	6,621	6,132	-489	101.88%	£1,279,357	£1,188,179	-£91,178
03_First Attendance without Procedures	110%	£9,002,781	£12,769,602	£3,766,821	149.61%	42,395	57,014	14,619	142.20%	£12,765,944	£12,769,602	£3,658
04_Follow Up Attendance with Procedure	110%	£1,515,163	£1,760,905	£245,742	122.59%	10,276	10,762	486	115.20%	£1,327,677	£1,760,905	£433,228
Grand Total	**106%**	**£21,968,990**	**£27,580,319**	**£5,611,329**	**132%**	**66,136**	**84,136**	**18,000**	**135%**	**£25,215,397**	**£27,580,319**	**£2,364,922**

NHSE are yet to publish any 2024/25 performance data, which should be available later in Q2. The NHSE performance variances are expected to be higher due to NHSE using the Trust's freeze data, whilst the Trust are using the indicative partially coded month to estimate the values. The anticipated change in reporting of SDEC (Same Day Emergency Care) activity is a risk to ERF income and the Trust is in active dialogue with NHSE as to how this can be managed.

In addition, the Trust is yet to receive the outstanding 2023/24 ERF performance payments for BOB West ICB which has been escalated. The final publication of 2023-24 ERF performance is expected in Q2 which may lead to adjustment of the ERF target for 2024-25 to recognise the prior year over-performance.

Key message
Overall, ERF continues to over perform in 2024/25 which is a continuation of the 2023/24 performance position. This has resulted in a favourable year to date income variance to Plan of £1.9m. Risks relating to this income involve mandated changes to SDEC activity reporting as well as the uncertainty associated with the delay in publication of NHSE official performance.

CASH

7. Summary of Cash Flow

The cash balance at the end of July was £17.5m, £5.0m behind the planned figure of £22.5m, (due to the delay in receipt of ERF income which was planned to have been received earlier in the year) and a £1.0m increase on last month's figure of £16.5m (see opposite). The main reason for the in-month increase was £0.2m of capital expenditure in M4, that related to FY24 business cases, offset by a £1.2m surplus in operating working capital.

8. Cash arrangements 2024/25

The Trust will continue to receive much of its income via block funding for FY25, which includes an uplift for growth, plus additional incentive funding linked to activity delivery and funding for high-cost drugs on a pass-through basis.

Key message

Cash at the end of July was £5.0m behind plan. There was a month on month increase of £1.0m from June, due to capital expenditure, offset by an in-month working capital surplus.

BALANCE SHEET

9. Statement of Financial Position

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

- Non-Current Assets have increased from March 24 by £0.6m; this is driven by a £2.0m increase in tangible assets, offset by a £0.7m decrease in the Right of Use assets, and a £0.8m decrease in Intangible assets.
- Current assets have decreased by £2.7m; this is due to the increase in other receivables of £6.5m and in NHS receivables of £0.5m, offset by a decrease in cash of £9.7m.
- Current liabilities have decreased by £2.9m; this is due to the £0.7m increase in deferred income, offset by the £3.1m decrease in payables and £0.7m decrease in Right of Use assets liability.
- Non-Current Liabilities have increased from March 24 by £0.3m; this is due to the Right of Use assets, related to IFRS 16.

10. Aged debt

- The debtors position as of July 24 is £2.4m, which is an increase of £0.4m from the prior month. Of this total £0.8m is over 121 days old.

11. Creditors

- The creditors position as of July 24 is £6.5m, which is a decrease of £2.1m from the prior month. £2.5m is over 30 days of ageing with £1.5m approved for payment.

Key message
Main movements in year on the statement of financial position are the reduction in cash of £9.7m, other receivables increase of £6.5m, the current liabilities decrease of £2.9m.

RECOMMENDATIONS TO BOARD

12. Trust Board is asked to note the financial position of the Trust as of 31st July 2024 and the proposed actions and risks therein.

APPENDICIES

Appendix 1

Statement of Comprehensive Income
For the period ending 31st July

	FY25	M4 CUMULATIVE			M4			PRIOR MONTH	
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance	M3 Actual	Change
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME									
Outpatient First	33,734	10,965	14,283	3,317	2,605	3,457	852	3,607	(150)
Outpatient Procedures	5,076	1,273	1,959	686	415	1,594	1,179	156	1,438
Chemotherapy delivery	2,435	849	686	(163)	209	162	(47)	178	(16)
Day Case Admissions	21,191	6,626	8,504	1,878	1,664	2,027	363	1,963	64
Elecitve Admissions	16,667	4,984	5,340	356	1,400	1,544	144	882	662
High Cost Drugs & Devices	25,432	8,216	8,216	0	2,287	2,285	(1)	1,691	595
Total Variable Income	***104,535***	***32,913***	***38,988***	***6,074***	***8,580***	***11,069***	***2,489***	***8,476***	***2,593***
Outpatient Follow up	24,433	7,946	6,933	(1,013)	1,889	1,041	(848)	1,927	(887)
Emergency Admissions	92,557	30,864	30,867	3	7,942	7,948	6	7,492	456
A&E	20,484	6,798	6,798	(0)	1,721	1,720	(0)	1,664	56
Other Admissions	16,950	5,820	829	(4,991)	1,273	187	(1,086)	240	(53)
Maternity Other (Including Deliveries_	0	0	4,991	4,991	0	1,086	1,086	1,481	(395)
Maternity pahtway (ante/post natal)	9,026	3,162	3,166	4	869	869	0	793	76
Critical Care (adult)	4,164	1,129	1,127	(1)	294	293	(0)	141	153
Neonatal	3,728	1,186	1,186	0	264	264	0	301	(37)
Imagin	7,363	2,132	2,132	0	497	497	(0)	408	90
Direct Access Pathology	6,123	1,995	1,974	(21)	516	495	(21)	458	37
Best Practice Tariffs	627	201	201	(0)	50	50	(0)	47	4
Other block income	8,513	2,852	2,852	(0)	709	709	0	724	(14)
Total Block / Fixed Income	***193,968***	***64,085***	***63,056***	***(1,030)***	***16,024***	***15,160***	***(864)***	***15,674***	***(515)***
Non-recurent & additional income	0	1,407	(1,453)	(2,860)	35	(188)	(223)	94	(282)
National Block	64,786	21,595	21,595	0	5,399	5,399	(0)	5,399	0
Clinical Income	**361,218**	**120,001**	**122,185**	**2,184**	**30,038**	**31,440**	**1,402**	**29,643**	**1,797**
Non-Patient Income	25,256	8,450	8,625	175	1,775	2,068	293	2,180	(112)
Donations	6,293	388	5,008	4,620	0	(380)	(380)	0	(380)
Non-Patient Income	**31,550**	**8,838**	**13,633**	**4,795**	**1,775**	**1,689**	**(87)**	**2,180**	**(492)**
TOTAL INCOME	**392,768**	**128,839**	**135,818**	**6,979**	**31,814**	**33,129**	**1,315**	**31,823**	**1,305**
EXPENDITURE									
Pay - Substantive	(228,587)	(76,282)	(72,594)	3,689	(18,750)	(18,050)	700	(18,276)	226
Pay - Bank	(10,361)	(3,438)	(6,543)	(3,105)	(859)	(1,628)	(769)	(1,603)	(26)
Pay - Locum	(2,200)	(733)	(2,314)	(1,580)	(183)	(631)	(447)	(593)	(38)
Pay - Agency	(5,045)	(1,879)	(3,190)	(1,311)	(450)	(788)	(338)	(821)	33
Pay - Other	(942)	(314)	(339)	(25)	(78)	(82)	(4)	(86)	3
Pay CIP	36	12	0	(12)	3	0	(3)	0	0
Vacancy Factor	50	17	0	(17)	4	0	(4)	0	0
Pay	**(247,049)**	**(82,618)**	**(84,980)**	**(2,362)**	**(20,314)**	**(21,179)**	**(865)**	**(21,379)**	**199**
Non Pay	(90,106)	(33,326)	(32,610)	716	(8,403)	(8,330)	73	(7,863)	(467)
Non Tariff Drugs (high cost/individual drugs)	(25,096)	(8,375)	(9,651)	(1,276)	(2,048)	(2,767)	(718)	(1,961)	(805)
Non Pay	**(115,203)**	**(41,702)**	**(42,261)**	**(559)**	**(10,451)**	**(11,097)**	**(645)**	**(9,825)**	**(1,272)**
TOTAL EXPENDITURE	**(362,251)**	**(124,319)**	**(127,241)**	**(2,921)**	**(30,766)**	**(32,276)**	**(1,510)**	**(31,203)**	**(1,072)**
EARNINGS BEFORE INTEREST, TAXATION, DEPRECIATION AND AMORTISATION (EBITDA)	**30,517**	**4,520**	**8,578**	**4,058**	**1,048**	**853**	**(195)**	**620**	**233**
Interest Receivable	480	160	376	216	40	111	71	104	7
Interest Payable	(1,268)	(423)	(194)	229	(106)	(48)	57	(48)	0
Depreciation, Impairments & Profit/Loss on Asset Disposal	(16,979)	(5,559)	(5,590)	(31)	(1,409)	(1,418)	(9)	(1,320)	(98)
Donated Asset Depreciation	(707)	(232)	(203)	29	(58)	(51)	7	(52)	1
Profit/Loss on Asset Disposal & Impairments	0	0	0	0	0	0	0	0	0
DEL Impairments	0	0	(232)	(232)	0	(58)	(58)	(58)	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	**12,044**	**(1,534)**	**2,735**	**4,269**	**(485)**	**(612)**	**(127)**	**(755)**	**143**
Dividends Payable	(6,457)	(2,152)	(2,210)	(57)	(538)	(552)	(14)	(581)	29
OPERATING SURPLUS/(DEFICIT) AFTER DIVIDENDS	**5,586**	**(3,686)**	**525**	**4,212**	**(1,023)**	**(1,164)**	**(141)**	**(1,336)**	**172**

Appendix 2

Statement of Cash Flow
As of 31st July 2024

	Mth12 2023-24 £000	Mth 4 £000	Mth 3 £000	In Month Movement £000
Cash flows from operating activities				
Operating (deficit)/surplus from continuing operations	13,970	2,787	3,402	615
Operating (deficit)/surplus from continuing operations	**13,970**	**2,787**	**3,402**	**615**
Non-cash income and expense:				
Depreciation and amortisation	17,229	5,791	4,323	(1,468)
Impairments	0	0	0	0
(Increase)/Decrease in Trade and Other Receivables	(3,720)	(6,914)	(6,863)	51
(Increase)/Decrease in Other Assets	0	0	0	0
(Increase)/Decrease in Inventories	(127)	0	0	0
Increase/(Decrease) in Trade and Other Payables	544	(5,186)	(4,144)	1,042
Increase/(Decrease) in Other Liabilities	(6,967)	857	(766)	(1,623)
Increase/(Decrease) in Provisions	8,698	(108)	(32)	76
Income in respect of capital donations	(8,415)	(5,008)	(5,336)	(328)
Other movements in operating cash flows	891	0	(3)	(3)
NET CASH (USED IN) GENERATED FROM OPERATIONS	**22,103**	**(7,781)**	**(9,419)**	**(1,638)**
Cash flows from investing activities				
Interest received	1,399	376	265	(111)
Addition of ROU assets	0	0	0	0
Purchase of intangible assets	(425)	(59)	(66)	(7)
Purchase of Property, Plant and Equipment	(34,087)	(6,649)	(5,982)	667
Process from sale of Property, Plant and Equipment	252	0	0	0
Net cash (used in) investing activities	**(32,861)**	**(6,332)**	**(5,783)**	**549**
Cash flows from financing activities				
Public dividend capital received	11,039	0	0	0
Capital element of finance lease rental payments	(5,078)	(195)	(196)	(1)
Unwinding of discount	0	(232)	(174)	58
Interest element of finance lease	(680)	(194)	(145)	49
PDC Dividend paid	(5,725)	0	0	0
Receipt of cash donations to purchase capital assets	8,415	5,000	5,000	0
Net cash generated from/(used in) financing activities	**7,971**	**4,379**	**4,485**	**106**
(Decrease)/increase in cash and cash equivalents	**(2,787)**	**(9,734)**	**(10,717)**	**(983)**
Opening Cash and Cash equivalents	**27,208**	**27,208**	**27,208**	
Closing Cash and Cash equivalents	**27,208**	**17,474**	**16,491**	**(983)**

Appendix 3

Statement of Financial Position as of 31st July 2024

	Mar-24 Audited	Jul-24 YTD Actual	YTD Mvmt	% Variance
Assets Non-Current				
Tangible Assets	241.4	243.4	2.0	0.8%
Intangible Assets	16.6	15.8	(0.8)	(4.8%)
ROU Assets	18.6	17.9	(0.7)	(3.8%)
Other Assets	3.2	3.3	0.1	3.1%
Total Non Current Assets	**279.8**	**280.4**	**0.6**	**0.2%**
Assets Current				
Inventory	5.3	5.3	0.0	0.0%
NHS Receivables	12.0	12.5	0.5	4.2%
Other Receivables	7.5	14.0	6.5	86.7%
Cash	27.2	17.5	(9.7)	(35.7%)
Total Current Assets	**52.0**	**49.3**	**(2.7)**	**(5.2%)**
Liabilities Current				
Interest -bearing borrowings	(1.5)	(1.1)	0.4	(26.7%)
Deferred Income	(11.6)	(12.3)	(0.7)	6.0%
Provisions	(11.7)	(11.6)	0.1	(0.9%)
Trade & other Creditors (incl NHS)	(60.8)	(57.7)	3.1	(5.1%)
Total Current Liabilities	**(85.6)**	**(82.7)**	**2.9**	**(3.4%)**
Net current assets	**(33.6)**	**(33.4)**	**0.2**	**(0.6%)**
Liabilities Non-Current				
Long-term Interest bearing borrowings	(18.2)	(18.5)	(0.3)	1.6%
Deferred Income	(0.5)	(0.5)	0.0	0.0%
Provisions for liabilities and charges	(1.6)	(1.6)	0.0	0.0%
Total non-current liabilities	**(20.3)**	**(20.6)**	**(0.3)**	**1.5%**
Total Assets Employed	**225.9**	**226.4**	**0.5**	**0.2%**
Taxpayers Equity				
Public Dividend Capital (PDC)	294.2	294.2	0.0	0.0%
Revaluation Reserve	64.6	64.6	0.0	0.0%
Financial assets at FV through OCI reserve	(2.6)	(2.6)	0.0	0.0%
I&E Reserve	(130.3)	(129.8)	0.5	(0.4%)
Total Taxpayers Equity	**225.9**	**226.4**	**0.5**	**0.2%**

GLOSSARY OF TERMS

Abbreviation	Full name	Explanation
A/L	Annual Leave	Impact of staff annual leave
BAU	Business as usual	In the context of capital expenditure, this is the replacement of existing capital assets on a like for like basis.
BPP	Better payment practice	This requires all NHS Organisations to achieve a public sector payment standard for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services – the target for this is 95%
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

Meeting Title	**Trust Board (Public)**	**Date: 5 September 2024**
Report Title	Workforce Report – M4	**Agenda Item Number: 12**
Lead Director	Louise Clayton, Acting Chief People Officer	
Report Author	Louise Clayton, Acting Chief People Officer	

Introduction	This report provides an update on workforce activity and compliance for M4 2024-25		
Key Messages to Note	The KPI for turnover has now been met for the first time in over 13 months The vacancy rate continues to fall Agency and bank usage remain a key area of focus for reduction The introduction of improved onboarding toolkits and management resources as well as Values Based Interviewing are all in train and key deliverables within the 2024-2027 Workforce Strategy		
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)***	Employ and retain the best people to care for you

Report History	This is the first version of this report
Next Steps	JCNC and Trust Executive Committee
Appendices/Attachments	None

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators as at 31 July 2024 (Month 4), covering the preceding 13 months.

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

Indicator	Measure	Target	07/2023	08/2023	09/2023	10/2023	11/2023	12/2023	01/2024	02/2024	03/2024	04/2024	05/2024	06/2024	07/2024
Staff in post *(as at report date)*	Actual WTE		3776.8	3744.1	3758.3	3775.2	3820.9	3826.0	3834.9	3850.3	3869.1	3861.1	3880.6	3879.2	**3913.0**
	Headcount		4293	4261	4278	4296	4351	4352	4368	4381	4402	4392	4415	4412	**4449**
Establishment *(as per ESR)*	WTE		3963.2	3965.5	3962.0	3996.0	4005.3	4001.9	4012.1	4008.1	4018.1	4109.9	4144.0	4156.7	**4162.7**
	%, Vacancy Rate - Trust Total	**10.0%**	4.7%	5.6%	5.1%	5.5%	4.6%	4.4%	4.4%	3.9%	3.7%	6.1%	6.4%	6.7%	**6.0%**
	%, Vacancy Rate - Add Prof Scientific and Technical		25.6%	25.1%	20.6%	16.1%	15.7%	19.5%	18.6%	17.7%	16.1%	19.9%	21.4%	22.2%	**23.0%**
	%, Vacancy Rate - Additional Clinical Services *(Includes **HCA**s)*		0.3%	3.1%	3.4%	8.2%	9.5%	11.1%	16.0%	15.3%	15.3%	16.3%	15.5%	14.7%	**14.4%**
	%, Vacancy Rate - Administrative and Clerical		2.8%	3.1%	3.7%	3.6%	3.1%	2.1%	1.5%	1.6%	1.4%	2.9%	2.9%	3.1%	**2.8%**
	%, Vacancy Rate - Allied Health Professionals		17.1%	15.3%	16.9%	15.0%	16.0%	16.0%	15.3%	13.1%	12.1%	11.6%	17.0%	18.6%	**18.0%**
	%, Vacancy Rate - Estates and Ancillary		6.2%	7.0%	7.8%	8.0%	4.6%	4.9%	3.6%	3.8%	4.3%	9.2%	8.7%	8.2%	**7.7%**
	%, Vacancy Rate - Healthcare Scientists		6.2%	6.1%	6.0%	4.2%	0.0%	-1.7%	-0.5%	0.2%	-0.9%	4.1%	5.2%	5.0%	**2.6%**
	%, Vacancy Rate - Medical and Dental		0.0%	1.4%	0.4%	0.0%	0.0%	-2.3%	-1.8%	-1.0%	-1.3%	1.4%	2.1%	3.0%	**-0.5%**
	%, Vacancy Rate - Nursing and Midwifery Registered		7.6%	6.2%	4.3%	4.2%	2.5%	1.3%	-0.8%	-2.0%	-2.2%	0.9%	0.8%	1.5%	**1.5%**
Staff Costs (12 months) *(as per finance data)*	%, Temp Staff Cost (%, £)		14.8%	14.5%	14.0%	13.7%	13.4%	12.7%	12.4%	12.2%	12.2%	11.9%	11.7%	11.7%	**11.7%**
	%, Temp Staff Usage (%, WTE)		14.0%	13.8%	13.5%	13.3%	13.1%	12.8%	12.6%	12.4%	12.2%	12.2%	12.0%	11.9%	**11.9%**
Absence (12 months)	%, 12 month Absence Rate	**5.0%**	4.5%	4.5%	4.5%	4.5%	4.6%	4.6%	4.7%	4.7%	4.7%	4.8%	4.8%	**4.8%**	*4.8%*
	- %, 12 month Absence Rate - Long Term		*2.3%*	*2.4%*	*2.3%*	*2.4%*	*2.5%*	*2.5%*	*2.6%*	*2.5%*	*2.6%*	*2.6%*	*2.6%*	***2.6%***	*2.6%*
	- %, 12 month Absence Rate - Short Term		*2.2%*	*2.2%*	*2.2%*	*2.1%*	*2.1%*	*2.1%*	*2.2%*	*2.2%*	*2.1%*	*2.2%*	*2.2%*	***2.2%***	*2.2%*
	%,In month Absence Rate - Total		4.2%	4.0%	4.1%	5.1%	5.0%	5.6%	5.6%	5.0%	4.5%	4.8%	4.4%	**4.3%**	*4.9%*
	- %, In month Absence Rate - Long Term		*2.4%*	*2.3%*	*2.3%*	*3.0%*	*3.0%*	*3.1%*	*3.0%*	*2.8%*	*2.7%*	*2.4%*	*2.4%*	***2.4%***	*2.7%*
	- %, In month Absence Rate - Short Term		*1.8%*	*1.7%*	*1.8%*	*2.1%*	*2.0%*	*2.5%*	*2.6%*	*2.2%*	*1.8%*	*2.4%*	*2.0%*	***2.0%***	*2.2%*
Starters, Leavers and T/O rate (12 months)	WTE, Starters (In-month)		73.3	35.6	56.0	27.0	58.9	24.8	46.0	38.0	41.4	31.8	44.8	43.0	**34.4**
	Headcount, Starters (In-month)		83	42	62	30	68	28	51	42	48	36	52	49	**43**
	WTE, Leavers (In-month)		41.8	37.2	45.4	18.3	27.3	29.6	38.7	28.0	28.6	40.2	34.9	33.4	**32.1**
	Headcount, Leavers (In-month)		47	42	58	24	30	38	44	34	36	49	39	42	**36**
	%, Leaver Turnover Rate (12 months)	**12.5%**	14.4%	14.1%	14.1%	13.1%	13.0%	12.9%	12.8%	13.0%	12.6%	13.2%	13.1%	13.1%	**12.5%**
Statutory/Mandatory Training	%, Compliance	**90.0%**	96%	95%	95%	95%	96%	96%	95%	94%	94%	95%	96%	95%	**94%**
	Moving and Handling - Level 1 - 3 Years											94.0%	94.0%	94.0%	**93.0%**
	Moving and Handling - Level 2 - 3 Years											94.0%	94.0%	94.0%	**94.0%**
Appraisals	%, Compliance	**90%**	93%	91%	90%	89%	89%	90%	90%	91%	92%	92%	92%	91%	**91%**
Time to Hire (days)	General Recruitment	**35**	50	43	50	49	46	50	48	44	43	49	54	48	**44**
	Medical Recruitment (excl Deanery)	**35**	49	51	53	98	93	45	62	69	52	79	76	51	**54**
Employee relations	Number of open disciplinary cases		13	16	19	20	21	21	22	21	19	16	20	12	**18**

2.1. **Temporary staffing usage** has remained the same for the past 2 months, although there is an overall improvement in the 12 month period. Bank usage is currently under review to ensure that all Nursing and Healthcare Support Worker shift requests are approved by a senior nurse prior to being approved on Health Roster.

2.2. The Trust's **headcount has increased** and there are now 4449 employees in post. The **vacancy rate** has started to decrease (6%) following increases in budgeted establishment since the start of the financial year.

2.3. **Staff absence is at 4.8%** for the 12 month period and has increased to 4.9% in month. An increase in covid is having an impact on short term absence. Managers continue to support staff back to work in line with our sickness absence and attendance policy. Bespoke work to identify pockets of high absence is being carried out by the HRBPs.

2.4. **Staff turnover** has improved to 12.5%, meeting the Trust's KPI for the first time in over 13 months. Retention projects in areas of high turnover continue and the HRBPs are carrying out bespoke pieces of work where turnover is high. Healthcare Support Workers remain an area of focus for improved retention.

2.5. **Time to hire** has decreased to 44 days. The manageable delays in processes are being reviewed to close the timeline where possible. The Specialist Recruitment Managers are working with Divisions to support with recruitment to help close the gaps where clinical commitments delay the administration of recruitment.

2.6. The number of **open disciplinary cases** is 18. A detailed Employee Relations case report is produced monthly to JCNC and the Annual Employee Relations Report was presented to Workforce Development and Assurance Committee in M4.

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

2.8. There are 7.66 wte nursing vacancies. There are some areas such as Theatres that appear to be over-recruited due to their budgeted establishment being set against Operating Department Practitioners rather than Nursing roles. Some over-establishment in ward areas due to escalation wards being staffed with some substantive staff will also have an impact on this. Nursing recruitment where posts are vacant continues, particularly in ED and Theatres.

2.9. There are **92 HCSW vacancies** (B2 and B3 and including Maternity Support Workers) across the Trust with 8 in pre-employment and 13 with start date booked. Recruitment is ongoing in this area.

3. Continuous Improvement, Transformation and Innovation

3.1. The revamped **Onboarding and Induction ePack,** part of the improvements to onboarding processes the team have been working on, is now live. This is an electronic pack for new starters which has all the information they need to support them in their induction and ongoing employment. There is also a resource pack for newly appointed Managers which is full of useful resources and information due to be launched in Q3. Both packs are electronic and sent with the final offer letter to new starters.

3.2. The **Health and Wellbeing Resource ePack** is now live. This pack helps both staff and managers navigate the core offering from the Health and Wellbeing, Occupational Health and HR Teams. Referral templates, access to services within the Trust, and information on mental and emotional, physical, financial, and social wellbeing are all available in this electronic booklet.

3.3. Viv-up, the Trust's benefits and Employee Assistance Programme provider, has now opened two further portals in line with the planned contract renewal and relaunch. These two portals give staff access to travel and leisure options as well as a GP Online service.

4. Culture and Staff Engagement

4.1. The Staff Survey Protect and Reflect event is due to launch at the end of September. Staff will be able to book their Flu and Covid vaccinations and complete their staff survey. This year those completing and returning the survey will be offered a Blue Light Card or restaurant voucher. The **'You Said – We Did'** campaign will be prevalent in the waiting area as well as sharing information on staff benefits.

4.2. Surviving in Scrubs training was delivered to 24 clinicians and AHP's in response to the BMA's report on sexism in medicine that published statistics that 55% of female doctors and 34.1% of male doctors confirmed that there were concerns of sexism in their workplaces. The Human Factors agenda is also being adapted to include coping strategies to deal with sexism in the workplace.

4.3. Values Based Recruitment is due to be launched in Q3. Training will be launched alongside a suite of interview questions to support recruitment selection. This project is part of the cultural improvement work, focusing on fair processes and selection under the Workforce Strategy deliverables.

5. Current Affairs & Hot Topics

5.1. The workforce team are working closely with Divisions to review bank and agency usage and spend. Reviews of additional duties, retrospective bank shifts, and long-line bank usage is being carried out through the Temporary Staffing Group and HR Business Partners. Ensuring that the appropriate Resourcing Panel approval is in place for bank, in addition to putting in place restrictions on bank approvals, will support this improvement work and embed governance around practices.

6. Recommendations

6.1. Members are asked to note the report.

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TRUST BOARD IN PUBLIC

Academic Centre/Teams

Thursday, 05 September 2024

New Hospital Project Update

John Blakesley
Deputy Chief Executive

Verbal/Discuss

Meeting Title	Trust Board (Public)	**Date: 5 September 2024**
Report Title	Equality, Diversity, and Inclusion Annual Report 2023-24	**Agenda Item Number: 14**
Lead Director	Louise Clayton, Acting Chief People Officer	
Report Author	Georgia Meakes, HR Business Partner	

Introduction	This Equality, Diversity and Inclusion annual report contains information on activity, performance and compliance and Trust action plans for 2023-2024. This report and its action plans will be published on the Trust internet by 31st October in order to satisfy our Public Sector Equality Duty.		
Key Messages to Note	The Trust now has eight networks, with the Neurodiversity network newly formed in the year. Cultural review work commenced with a focus into talent management and recruitment, led by Roger Kline. The number of staff declaring to have a disability has increased following the staff census. The action plans in Appendix A feed into the Workforce Strategy 2024-2027.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☒	**For Approval** ☐	**For Review** ☐

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	To employ and retain the best people to work for you

Report History	This report has also been submitted to Trust Executive Committee in August 2024
Next Steps	Publication on the Trust internet by 31st October 2024
Appendices/Attachments	Appendix A: Action Plan Appendix B: Workforce Profile

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Workforce Equality, Diversity, and Inclusion Annual Report 2023-2024

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Foreword

Here at Milton Keynes University Hospital, we are committed to ensuring that Equality, Diversity and Inclusion (EDI) is at the heart of everything we do.

Like every NHS organisation, MKUH has an immensely diverse workforce comprising of many different cultures and backgrounds. This brings with it the benefits of so many different perspectives, experiences and identities. I firmly believe that when an organisation fosters a safe and inclusive workplace with team members who have a diverse range of backgrounds and cultures, this in turn leads to better and safer services for our patients.

Equality, Diversity and Inclusion are all interconnected, but they are not interchangeable nor are they mutually exclusive. Equality is about ensuring that every single person who works for us has equal opportunities and chances within our hospital. Diversity means we acknowledge people's differences in a variety of ways, from their backgrounds to the way they identify themselves. And Inclusion means we embrace and value these differences in the knowledge that this leads to a stronger and more inclusive place to work and be treated as a patient.

I am very proud of the way MKUH staff work tirelessly to ensure that EDI is at the heart of everything we do. In the past year, we have taken further steps to ensure EDI remains centre-stage. I am pleased to note that we now have eight different staff networks, each one sponsored by a member of the executive team. We have undertaken a cultural review by race equality expert, Research fellow and acclaimed author Roger Kline, which will lead us into a more in-depth analysis on EDI in the future. We have signed up to NHS England's Sexual Safety Charter. We make a point of celebrating many different occasions – from Black History Month to Armed Forces Day and South Asian heritage month – all of which encourage staff from other backgrounds to learn more about their colleagues' culture and experiences.

While we have taken great strides over the last 12 months, there is still much more we can do and this report highlights just some of the ways we are seeking to improve experiences for every single colleague and patient moving forward.

I hope you find this report both encouraging and enlightening, reflecting the importance I place on leading a diverse and inclusive workforce with positive results.

Joe Harrison
Chief Executive
Milton Keynes University Hospital

Context

Milton Keynes is a culturally diverse community which is growing at pace, with the population increasing by 15.3% between 2011 and 2021 as per the national census data[1].

As one of the largest employers in the area, Milton Keynes University Hospital (MKUH), is committed to creating a diverse workforce that is truly representative of the population we serve, where we celebrate difference, value everyone's contribution and where people of all backgrounds can thrive.

We value the diversity of our workforce and the range of knowledge, skills and experience our people bring to our work. We strive to create a working environment that promotes inclusion and gives everyone a sense of belonging.

MKUH is committed to providing services that meet each individual's needs, treating everyone with the compassion and respect they deserve.

Our vision and values act as principles to guide us in our thinking and actions. **Our equality objectives serve to promote these standards.**

Purpose

MKUH as a public sector body, is governed by the Equality Act 2010 and the Public Sector Equality Duty (PSED) in relation to its equality duties.

As part of these duties, we are required to publish equality information to demonstrate our compliance with the general equality duty on an annual basis. This report therefore includes the equality monitoring data for our workforce for the period 01 April 2023 to 31 March 2024.

Our workforce data forms part of the information we collate, monitor, and publish to help us embed equality considerations within our employment policies and practices and meet our responsibilities under the duty to;

- Promote equality, diversity, inclusion and belonging
- Eliminate discrimination and harassment
- Promote equality of opportunities
- Foster good relations between different groups within our workforce

This report outlines our achievements around equality, diversity, and inclusion highlighting the key pieces of work we have undertaken in the past year and states the future direction of the work around this agenda, with an action plan detailing key actions for the next year in Appendix A.

[1] Census 2021 | Milton Keynes City Council (milton-keynes.gov.uk)

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Equality, Diversity & Inclusion Strategy 2021-2024[2]

Corporate Objectives

Improving patient safety	Improving patient experience	Improving clinical effectiveness

Ambition

We will become an exemplar organisation for equality, diversity and inclusion

What Success Looks Like

Desirable place to work / preferred place to work for all people from diverse backgrounds	All our people are able to be their best	Individually and collectively, we add value to our patients, service users and communities of all diverse backgrounds	We are recognised as a diverse, inclusive, flexible organisation known for its 'Kind Culture'

Delivered by

Trust Board Actions	Staff Equality Networks	Divisional Actions	Internal and External Communications	Individual Actions

[2] Equality-Diversity-and-Inclusion-Strategy-2021-–-2024.pdf (mkuh.nhs.uk)

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Our Year at a Glance …

Neurodiversity Network launched

Gender pay gap reduced to 11.6%

Eight Staff Networks in place

Cultural review undertaken by Roger Kline, Research Fellow

Executive Sponsor secured for each Network

Training rolled out for Staff Networks Chairs & Deputies

Celebration of National Staff Networks Day

Approx. 200 employees engaged in Cultural Awareness Training

Signed up to the NHS England Sexual Safety Charter

Network Events held including the First Celebration of Windrush Day

N.B Roger Kline is a Research Fellow and author of reports on Race Equality in the NHS including 'The Snowy White Peaks of the NHS'

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NHS Improvement Plan Six High Impact Actions

The EDI Improvement Plan sets out six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable

Objectives

- Every board and executive tea ve EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process
- Board members should be able to demonstrate how organisational data and lived experience have been used to improve culture
- NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework

Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

Objectives

- Create and implement a talent management plan to improve the diversity of executive and senior leadership teams
- Evidence progress of implementation
- Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes

Action 3: Develop and implement an improvement plan to eliminate pay gaps

Objectives

- Implement the 'Mend the Gap' review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce
- Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026
- Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns

Action 4: Develop and implement an improvement plan to address health inequalities within the workforce

Objectives

- Line managers and supervisors should have regular effective wellbeing conversations with their teams
- Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare

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Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff

Objectives

- Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment; including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options.
- Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured from, for example, turnover, staff survey results and cohort feedback
- Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety
- Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression

Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

Objectives

- Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set and plans implemented to improve staff experience year-on-year.
- Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from Trust solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this.
- Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it.
- Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff
- Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence
- Have mechanisms to ensure staff who raise concerns are protected by their organisation.

Objectives in green have been achieved, all other objectives are in progress.

Staff Networks

At MKUH we are proud to have active staff networks that support our diverse community. We recognise they are essential to enhancing a culture of inclusivity, ensuring people can bring their whole selves to work and contribute to improving life at work for underrepresented groups and individuals.

The Trust is committed to making the organisation a more inclusive place to work and are looking into how we can better support our staff networks. As part of this, each network at MKUH has an Executive Sponsor who guides the groups and ensures their voices are heard. All networks are also involved in the Inclusion Leadership Council (ILC) which is led by the Trust chair.

Currently, our Trust has eight staff networks, each at varying stages of development:

BAME Network

The Black, Asian and Minority Ethnic (BAME) network believes that, in order for every individual to reach their full potential, there must be no fear of discrimination or prejudice and a belief that career opportunities or experience of work is not predetermined by ethnicity, nationality or colour. In support of this they have been working with Roger Kline on his cultural review to support this agenda at board level.

Over the past year, the network ran a number of events in support and recognition of BME employees including sessions for Black History Month under the theme of ‘Saluting our Sisters’, and a webinar celebrating Windrush Day, with a focus on staff sharing their lived experiences.

The network has continued to provide invaluable guidance and support to staff including through the promotion of freedom to speak up, coaching on interview techniques and encouraging continuous professional development (CPD) in order to create a safer and more inclusive workplace.

Currently the network is involved in a system level project aimed at addressing the disparities for global majority nurses, midwives, nursing associates and healthcare workers with regard to career progression for staff within the BAME community. This involves supporting a sustainable workforce plan across BLMK ICS and wider NHS.

Alice Holland,
BAME Network Chair

Women's Network

The MKUH Women's network provides a space for women not just to share their experiences, but also to become advocates for behaving differently in the workplace. Over the last year the Women's Network has grown significantly, doubling in size. Some of the key work undertaken includes;

- Fostered an inclusive and safe environment for members to share their lived experiences and learn from one another, ensuring this is fed back to the Trust.
- Hosted an International Women's Day event featuring sessions on boundary setting, burnout, and a relaxing sound bath.
- With the support of UNISON, launched a project to provide period supplies for the MKUH team.
- Gathered input from members on important issues such as the staff survey results, gender pay gap report, and menopause, and shared several policies for member comments to ensure their voices are heard.

Charlotte Naqvi,
Women's Network Chair

Ability Network

The Ability network is a friendly and supportive group which is keen to raise awareness of disability equality and share experiences. There is a lot of experience amongst people in the network of living with a range of disabilities, both visible and hidden. Members aim to draw on their shared experience to influence decisions to ensure that MKUH creates a positive workplace that is inclusive for everyone.

Stephanie Jones,
Ability Network Chair

Neurodiversity Network

The Neurodiversity network is the newest staff network having only been launched in March 2023. The network is open to all staff and volunteers who define themselves as neurodivergent and to allies who support the aims and objectives of the network.

The network aims to create a supportive working environment and policy framework for neurodivergent colleagues and to encourage all staff within the Trust to understand issues particularly affecting neurodivergent employees.

Over the next year the network will be focusing on;

- Developing a communication strategy to ensure all members are informed and engaged, with regular meetings and workshops for employees
- Enhancing awareness and education around neurodiversity within MKUH through a series of educational events including guest lectures, workshops and training sessions that cover topics such as recognising and supporting neurodiverse colleagues, the benefits of a neurodiverse workforce and strategies for inclusive practice
- Advocating for policy changes and the implementation of supportive practices that benefit neurodiverse staff within the Trust, providing them with the necessary resources and adjustments to thrive in their roles
- Establishing a formal support system, including a mentoring programme and peer support group for neurodiverse staff

Nicola Dryden,
Neurodiversity Network Chair

Carers Network

The Trust is in the process of supporting the set-up of a Carers network. It is currently a virtual network, and the aim is for this to develop into an inclusive group that supports staff at MKUH who are also carers.

The Carers network will offer peer to peer support and access to information and advice. This will help staff successfully manage the sometimes-conflicting demands of work and the carer's role.

Armed Forces Network (AFSN)

The AFSN is a safe, supportive network for those who have served, those still serving (reservists), their families, and anyone who is passionate about supporting them. As one of the newer staff networks they continue to grow year on year.

In the last year the network worked alongside the wider Trust to achieve the Ministry of Defence (MOD) Employer Recognition Scheme Gold Award as part of the Trust's ongoing commitment to supporting the armed forces community. This involved working with the Trust to ensure 'forces friendly' HR policies to support reservists with special leave so they can attend their mandatory annual military training, and spouses of those who are deployed on military operations.

They celebrated their service during Armed Forces Week in June and Reserves Day, with military organisations and reserve forces units invited in to raise awareness about the support available to the veterans in our local community.

Many members have now undertaken MH England's Armed Forces MH First Aid course and are now embedded 'Armed Forces Champions' within various departments, supporting colleagues and patients.

The network also recently achieved Fighting With Prides 'Pride in Veterans Standards' accreditation which supports those who were historically dismissed from service based on their sexuality and seeks to raise awareness around the issue.

JJ Hrycak
Armed Forces Network Chair

Faith and Belief Network

The Faith and Belief network is in the process of relaunching and is currently looking for a chair and deputy chair to support its agenda and help grow its membership base.

The network is passionate about celebrating all faiths and beliefs and in the last year has worked with wards to publicise the range of festivals and celebrations celebrated by the MKUH community through the use of faith and belief calendars.

Pride Network

The Pride network is a group of individuals from across the Trust who self-identify as being LGBTQ+ or are an ally of LGBTQ+ individuals.

The core aim of the network is to promote equality, diversity, inclusion and Pride in our LGBTQ+ staff and to assist MKUH to deliver better services for all, both staff and patients. The network wants to improve the working lives of LGBTQ+ staff by empowering them to feel safe and able to be “out” at work allowing all staff to bring their whole selves to work, which will benefit both colleagues and patients.

Catherine Crossan,
Pride Network Chair

Compliance Reporting

NHS Equality Delivery System (EDS)

The Equality Delivery System (EDS) is the foundation of equality improvement within the NHS and is an accountable improvement tool for organisations in England, to review and develop their approach to addressing health inequalities through three domains; Services, Workforce and Leadership.

Trusts are required to undertake an EDS assessment each year and for 2022/23 the Organisations EDS Rating was 16 – Developing.

The key actions to be undertaken following the publication of this report include;

- Review Trust equality impact assessments to ensure documents are fit for purpose, regularly reviewed and managers are appropriately trained
- Roll-out Behaviours Policy and Procedure
- Continue to roll-out Cultural Awareness training across the Trust

You can find the report on the Trust's EDS assessment for 2022/2023, which was published in February 2024, here: Equality-Delivery-System-EDS-Summary-Report-2023.pdf (mkuh.nhs.uk)

Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standards (WRES) are a collection of 9 metrics created to highlight any differences between the experience and treatment of white staff and BME staff in the NHS.

Trusts are expected to show progress against these metrics which include recruitment opportunities, likelihood of entering the disciplinary process and accessing non-mandatory training, in order to improve workforce equality and create a more inclusive environment.

Trusts are required to report and publish data on each metric on an annual basis.

The key findings from the 2023/2024 WRES are;

- The number of BME employees employed at the Trust has increased, but BME representation remains lower in more senior positions, although this has improved from the previous year in bands 6 – 8b.
- As with the previous year, a high proportion of the medical and dental workforce have chosen not to declare their ethnicity.
- BME candidates are less likely to be appointed from shortlisting than white candidates.
- BME employees are more likely to enter the formal disciplinary process than white employees.
- BME employees are more likely to access non-mandatory training and CPD than white employees.

The key actions to be undertaken following the publication of this report include;

- Continue to support the ongoing development of the BAME Network
- Continue to implement values-based recruitment practices and develop recruitment training covering best practice and unconscious bias to provide managers with a 'license to recruit'
- Implement a Fair and Just Culture panel to assess the need, independently and consistently for formal disciplinary action

You can find the full report covering the 01 April 2023 to 31 March 2024 here: MKUH-Workforce-Race-Equality-Standard-WRES-Report-2023-24.pdf

Workforce Race Disability Standard (WDES)

The Workforce Disability Equality Standards (WDES) are a collection of 10 metrics that aim to compare the workplace and career experiences of disabled and non-disabled staff.

Trusts are expected to show progress against these metrics which include recruitment opportunities and likelihood of entering the capability process, in order to improve workforce equality and create a more inclusive environment.

Trusts are required to report and publish data on each metric on an annual basis.

The key findings from the 2023/2024 WDES are;

- Following focused work by the Trust to increase disability declaration rates the number of employee's declaring they have a disability increased from the previous year
- As with the previous year, a high proportion of the medical and dental workforce have chosen not to declare their disability status
- Disabled candidates are less likely to be appointed from shortlisting than those without disabilities
- Disabled employees are over twice as likely to enter into a formal capability process than non-disabled employees. It is important to note this figure is based on a sample size of only 5 cases and that there has only been one formal capability case against a disabled employee in the past 2 years

The key actions to be undertaken following the publication of this report include;

- Continue to support the ongoing development of both the Ability and Neurodiversity networks
- Continue to work towards Disability Confident Level 3 (Leader) status
- Roll-out reasonable adjustment training for line managers and further promote the use of Employee Passports to ensure employees have the appropriate support to undertake their roles

You can find the full report covering the 01 April 2023 to 31 March 2024 here: MKUH-Workforce-Disability-Equality-Standard-WDES-Report-2023 -24.pdf

Gender Pay Gap

As MKUH employs more than 250 staff the Trust is required under the Equality Act 2010, to publish information on its gender pay audit.

The key findings from the 2023/2024 Gender Pay Gap report are;

- Gender pay gap reducing year on year, with the median gap moving from 20% in 2020 to 11.6% in 2024

The key actions to be undertaken following the publication of this report include;

- Review of senior role job adverts, ensuring gender decoder utilised and flexible working promoted on all adverts
- Encourage female career progression through coaching and mentoring, and positive action initiatives
- Implement Sexual Safety at Work Policy to address and prevent further challenges for females at work

You can find the full report covering the 01 April 2023 to 31 March 2024 here: MKUH-Gender-Pay-Gap-Report-2023-24.pdf

Appendix A - Action Plan

Action	Deadline	How will we measure success?
Continue to raise awareness of WRES and WDES metrics by creating and distributing infographic posters to be shared with staff networks, staff side representatives, and with staff in their departments.	Oct-24	Increased awareness of the Trust's position
Implement a staff network for international nurses to support those who have recently moved to the UK to commence employment.	Mar-25	Network to be up and running with elected leadership
Continue to roll out cultural awareness training to identified areas to educate employees on diversity and inclusion, discrimination, unconscious bias, microaggressions and empathy.	Ongoing	Attendance at sessions. Reduction in employee relations cases related to discrimination in these areas
Review Trust equality impact assessments to ensure documents are fit for purpose, regularly reviewed and managers are appropriately trained.	Mar-25	EQI template reviewed & updated Training rolled out on how to complete robust & accurate EQIs
Development and roll-out of a communications and education campaign on the subject of allyship.	Dec-24	Improved awareness of issues faced by underrepresented groups and how to support them
Development of Behaviours Policy and Procedure to incorporate the Trust's Behaviours Framework in addition to outlining the responsibilities of all employees to challenge poor behaviour and specific statements re racism, homophobia, transphobia, sexism, ableism etc.	Dec-24	Reduction in discrimination, bullying, harassment against BAME colleagues. Increase in incidents being reported
Implement values-based recruitment practices and develop detailed recruitment training covering recruitment best practice and bias in the recruitment process to provide managers with a 'license to recruit'.	Dec-24	Improved shortlisting of BAME colleagues. Improved staff survey scores in questions related to discrimination.
Implement a Fair and Just Culture panel to assess the need, independently and consistently, for formal disciplinary action, pushing for matters to be dealt with informally where appropriate, ensuring an ED&I team representative sits on the panel.	Dec-24	Reduction in formal disciplinary cases. Consistent and proportionate outcomes for instances of misconduct
Implement a new Talent Management Programme as part of The MKWay, ensuring visibility and access for BAME colleagues.	Mar-25	Increased BAME representation in senior bands/roles. Improved CPD metrics. Improved Staff Survey score on equal opportunities for development
Roll out workplace adjustment training for line managers to ensure they are equipped to identify and implement reasonable adjustments for their teams.	Jan-25	Improved staff survey score regarding reasonable adjustments.
Undertake a review of appraisal paperwork to ensure that it is accessible and fit for purpose for employees with disabilities	Dec-24	Improvement in staff survey results around appraisals.
Continue to undertake initiatives that build leadership portfolio to apply for and gain Disability Confident Leader Status	Mar-27	Successful application for leadership Status.
Undertake a deep dive into gender pay gap data, reviewing each band/grade and staff group, utilising this data to co-produce an action plan with the Women's Network incorporating the Mend the Gap themes/recommendations	Oct-24	Development and delivery of action plan. Improvement of GPG metrics.

Action	Deadline	How will we measure success?
Produce an ethnicity pay gap report to explore the impact of inequalities and lack of representation at senior levels	Oct-24	Review of GPG ethnicity data. Increase of BAME colleagues within senior bands
Create a talent management pathway for women, which offers coaching and mentoring, including reverse mentoring opportunities.	Mar-25	Increased representation of women within senior bands
Implement a Sexual Safety at Work Policy to address and prevent further challenges for females at work.	Dec-24	Published policy Reduction in sexual harassment cases
Share gender pay gap data with departments to ensure this is considered and helps form objectives and priorities in workforce and succession planning.	Oct-24	Robust workforce plans that include career development and succession plans for staff
Review of senior role job adverts, ensuring gender decoder utilised and flexible working promoted on all adverts	Oct-24	Increased applications by Women for more senior positions

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Appendix B - Workforce Profile

Ethnicity

Ethnic Group	Headcount	%
A White - British	1,999	45.32
B White - Irish	32	0.73
C White - Any other White background	252	5.71
C2 White Northern Irish	2	0.05
CA White English	11	0.25
CF White Greek	2	0.05
CK White Italian	2	0.05
CP White Polish	7	0.16
CQ White ex-USSR	1	0.02
CX White Mixed	1	0.02
CY White Other European	13	0.29
D Mixed - White & Black Caribbean	21	0.48
E Mixed - White & Black African	36	0.82
F Mixed - White & Asian	15	0.34
G Mixed - Any other mixed background	32	0.73
GA Mixed - Black & Asian	1	0.02
GF Mixed - Other/Unspecified	3	0.07
H Asian or Asian British - Indian	555	12.58
J Asian or Asian British - Pakistani	98	2.22
K Asian or Asian British - Bangladeshi	35	0.79
L Asian or Asian British - Any other Asian background	132	2.99
LA Asian Mixed	1	0.02
LB Asian Punjabi	1	0.02

LC Asian Kashmiri	1	0.02
LD Asian East African	1	0.02
LE Asian Sri Lankan	15	0.34
LF Asian Tamil	4	0.09
LG Asian Sinhalese	2	0.05
LH Asian British	2	0.05
LK Asian Unspecified	15	0.34
M Black or Black British - Caribbean	64	1.45
N Black or Black British - African	605	13.72
P Black or Black British - Any other Black background	36	0.82
PA Black Somali	5	0.11
PC Black Nigerian	17	0.39
PD Black British	4	0.09
PE Black Unspecified	3	0.07
R Chinese	46	1.04
S Any Other Ethnic Group	82	1.86
SC Filipino	41	0.93
SD Malaysian	1	0.02
SE Other Specified	21	0.48
Unspecified	36	0.82
Z Not Stated	158	3.58
Grand Total	**4,411**	**100.00**

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Disability

Disability	Headcount	%
No	3,723	84.40
Not Declared	123	2.79
Prefer Not To Answer	12	0.27
Unspecified	295	6.69
Yes	258	5.85
Grand Total	**4,411**	**100.00**

Gender

	Female %	Male %
Part Time	32.46	3.51
Full Time	46.38	17.64
Total	**78.85**	**21.15**

Sexual Orientation

Sexual Orientation	Headcount	%
Bisexual	61	1.38
Gay or Lesbian	50	1.13
Heterosexual or Straight	3,759	85.22
Not Disclosed	366	8.30
Other sexual orientation not listed	7	0.16
Undecided	5	0.11
Unspecified	163	3.70
Grand Total	**4,411**	**100.00**

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Religion

Religious Belief	Headcount	%
Atheism	550	12.47
Buddhism	31	0.70
Christianity	2,298	52.10
Hinduism	235	5.33
Islam	297	6.73
Jainism	3	0.07
Judaism	5	0.11
Not Disclosed	473	10.72
Other	265	6.01
Sikhism	25	0.57
Unspecified	229	5.19
Grand Total	**4,411**	**100.00**

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Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 5 September 2024**
Report Title	**Complaints and PALS Annual Report 2023/24**	**Agenda Item Number: 15**
Lead Director	*Kate Jarman, Chief Corporate Services Officer*	
Report Author	*Julie Goodman, Head of Patient and Family Experience*	

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

SUBJECT Complaints Annual Report

DATE April 2023 to March 2024

REPORT BY Julie Goodman, Head of Patient and Family Experience

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1. Executive Summary

This is the complaints annual report for Milton Keynes University Hospital NHS Foundation Trust (MKUH) for the period 1 April 2023 to 31 March 2024. In this year there were:

- 101045 attendees to the Emergency Department
- 26620 elective admissions
- 29460 emergency admissions
- 441082 outpatient attendances
- 3787 babies delivered.

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

National regulations are further supported by the publication of national reports including the Francis Report 2013, Clwyd and Hart Report 2013, Designing Good Together, Parliamentary and Health Service Ombudsman (PHSO) 2013, and My Expectations for Raising Concerns and Complaints (PHSO) 2015, the NHS Complaints Standards 2022 (PHSO). All reports highlight best practice in respect of dealing with concerns and complaints.

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

2. Summary of NHS Complaints Procedures

The Local Authority Social Services and NHS Complaints (England) Regulations 2009 are a Statutory Instrument that all Trusts, including Foundation Trusts, have a duty to implement. Whilst the procedures are not prescriptive the regulations set out various obligations for NHS bodies in relation to the handling of complaints. Since 1st April 2009 there has been a single approach across Health and Adult Social Care in dealing with complaints. The regulations set out a two-stage complaint system:

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

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

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

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

MKUH Complaints Process

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

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

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

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

The remit of PALS is to provide advice and information and deal with informal complaints and to provide guidance on how to make a formal complaint, if requested. The PALS team administrate the investigative process for any matters of concern that may have caused low or no harm and focus on resolving issues without the need for a formal process. If concerns are regarding current or treatment that has taken place very recently action should be taken to resolve the issues as soon as

possible to ensure the person goes on to have a good experience. Not every complaint needs to be resolved by an in-depth investigation.

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

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

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

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

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

4. Annual Complaint Figures

MKUH is organised into four core divisions, these are Surgical Services, Medical Services, Women and Children's Services, and Core Clinical Services. Each division is led by a triumvirate team which incorporates a Divisional Director, Divisional Chief Nurse, and an Associate Director of Operations, who are collectively supported by Corporate Services.

The complaint numbers during 2023/24 have been collated for each division and the number and type of complaints received has been closely monitored and analysed to identify themes and trends to inform future improvements.

A total of 1135 **complaints** (formal and informal) were received by the Trust during 2023/24. As detailed on the chart below, this is a very slight decrease from 2022/23 of 0.96% (n=1146). The number of formal complaints totalled 190 and informal complaints 945.

	Q1 Apr - Jun 23	Q2 Jul – Sep 23	Q3 Oct – Dec 22	Q4 Jan – Mar 24	TOTAL
Complaint Numbers	295	289	237	314	1135 complaints (n = 1146 2022/23 **decrease 0.96%**)

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

A key performance indicator (KPI) for the PALS team is to achieve resolution of 30% of the total concerns raised within 24 hours. This KPI was achieved in 2023/24 with a result of **50.1%** There was also an increase in the number of concerns resolved within 24 hours when compared to 2022/23, the increase amounted to 40.9% (n = 674 2022/23 and n = 950 2023/24).

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

5. Responding to complaints

Under current national legislation Trusts have six months in which to resolve a complaint to the satisfaction of the complainant providing a more flexible agreement with each complainant. However, MKUH aims to provide a response in as timely a manner as possible and work to an internal benchmark of 30 working days or 60 working days for formal complaints, depending on the severity of the complaint. Currently informal complaints raised through the PALS service are subject to a response time of 15 working days.

To ensure that people feel safe and supported to make a complaint, complainants are directed to additional information, advice, and advocacy support. Complainants are also signposted to the PHSO if they remain dissatisfied with the results of the Trust's investigation and complaint handling.

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

would like to receive their response, in writing or a meeting with responsible medical staff, or both.

6. Complaints referred to the Parliamentary Health Service Ombudsman

During 2023/24, 7 cases were referred to the PHSO as follows.

Total cases referred to the PHSO	Number of cases awaiting investigation by the PHSO	Number of cases where recommendation(s) made	Number of cases where the PHSO deemed there was no case to answer
7	5	0	2

In July 2024, the Trust received confirmation from the PHSO that a case referred to them in 2022 was to be partially upheld and recommendations have been made which need to be actioned in totality by October 2024. The complaint is regarding care provided by the Medicine Division.

The failings identified were:

- The Trust did not complete additional bed rail assessments and did not do enough to reduce the risk of the patient falling.
- The Trust did not provide adequate oral care to the patient.
- The Trust delayed addressing the patient's weight loss.

The actions required are:

1. The Trust to acknowledge and apologise to the complainant for the failings identified.
2. Within three months of the final report, the Trust should write a SMART action plan to address the failings identified. If the Trust has already made relevant improvements it should instead provide evidence of this.
3. The Trust should share its action plan with the complainant and send evidence of this to the PHSO.

The above action is being overseen by the Divisional Chief Nurse for Medicine.

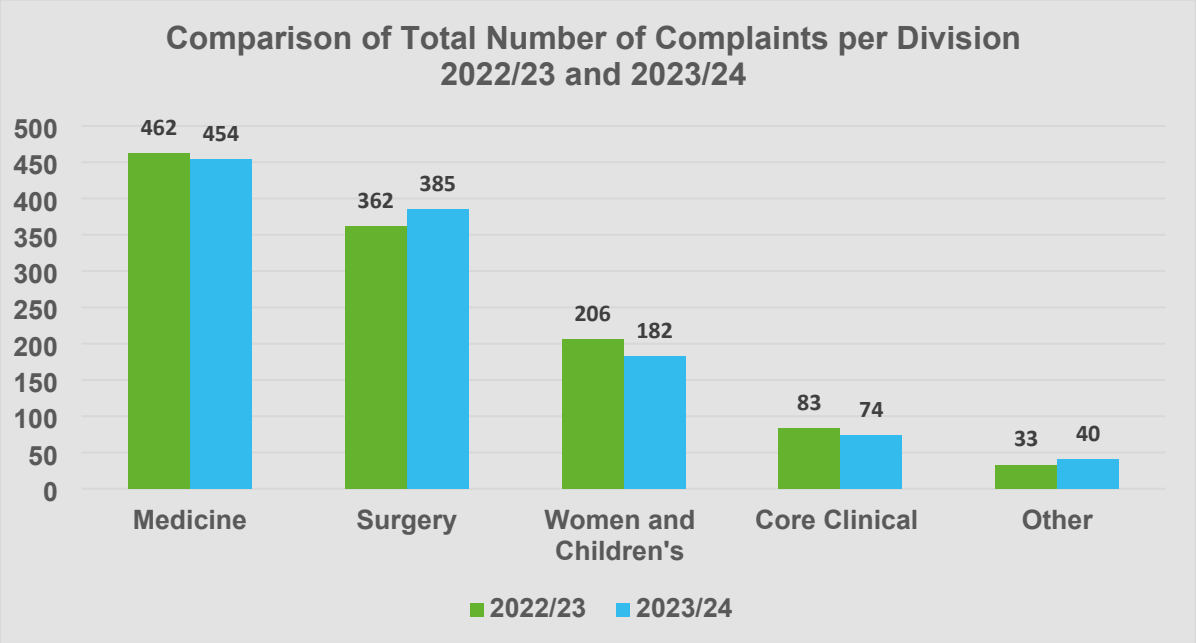
7. Complaint statistics

The 1135 complaints received in 2023/24 were represented across all divisions.

Complaints by division

The chart below compares the number of complaints received for the four main divisions for and 2022/23 and 2023/24.

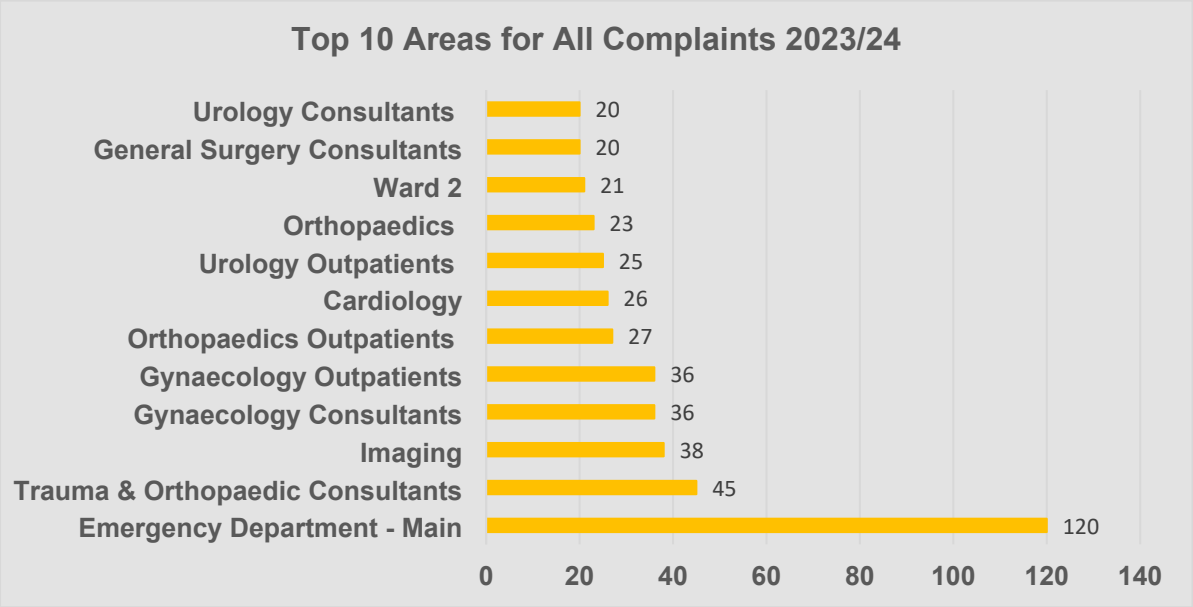
Chart 1 – Comparison of total number of complaints per division 2022/23 and 2023/24



8. Complaints by area

The chart below details the top areas receiving complaints in 2023/24.

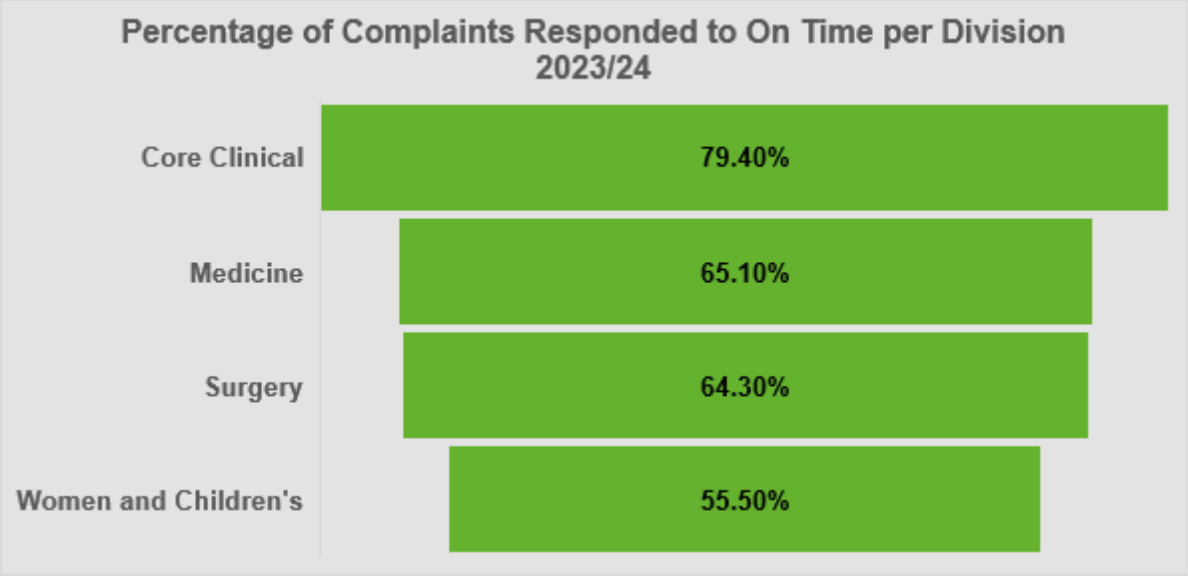
Chart 2 -Top areas for all complaints 2023/24



9. Responding

The chart below details the number of complaints responded to on time per division in percentage terms for 2023/24.

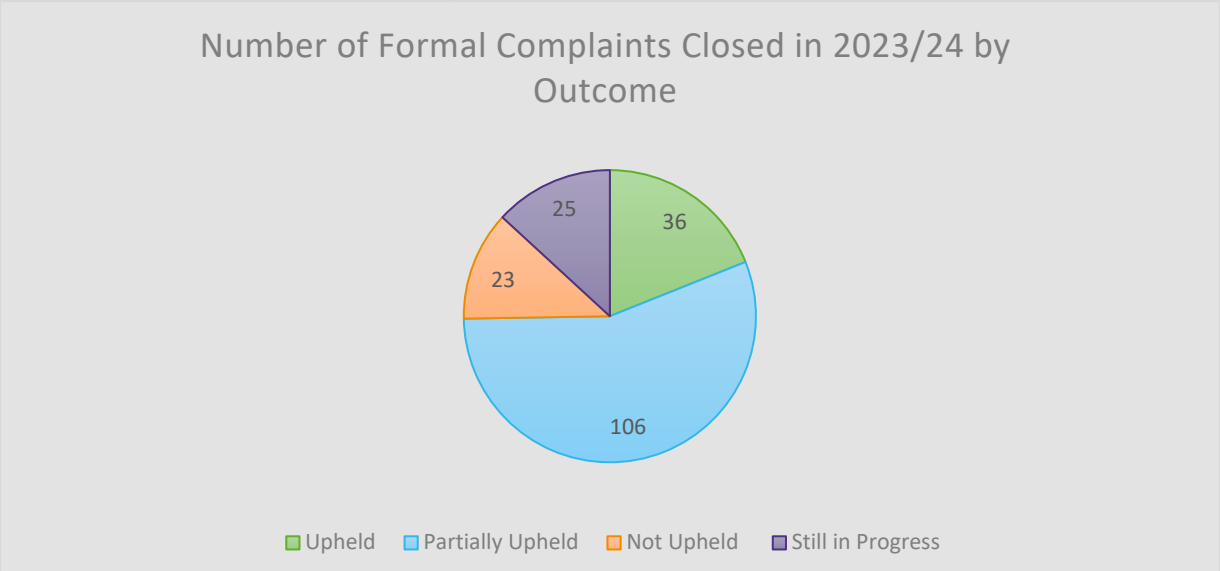
Chart 4 – Complaints responded to on time per division in percentage terms 2023/24



10. Complaints by outcome

Once a formal complaint investigation is complete, it can be determined whether the complaint is upheld in its entirety, partially upheld, or not upheld. The chart below shows the outcome of all formal complaints 2023/24**.** During this period there were 190 Amber complaints of which 25 are still in process at the time of writing this report.

Chart 5 – Closed Formal Complaints Outcome for 2023/24



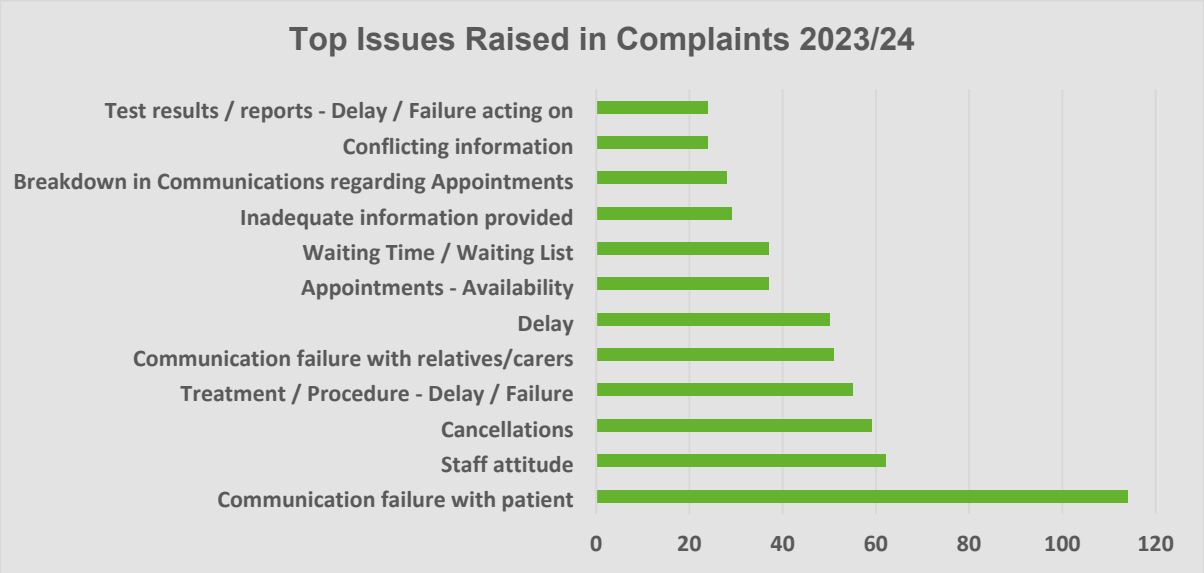
11. Category of Complaints

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

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

The chart below shows the top issues raised in complaints for 2023/24.

Chart 6 –Top Complaint Issues for 2023/24



Communication, staff attitude, treatment delays and appointment issues are the most complained about issues in all complaints for 2023/24.

12. Internal monitoring

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

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

13. Reopens

If a complainant remains unhappy with the response to their complaint, they are encouraged to return to the Trust with their outstanding issues. These files are reopened and further investigation, if required, takes place with the final resolution taking the form of a meeting with the complainant or a further written response.

The re-opening of a file takes place to enable the Trust to understand why a complainant is unhappy with their initial complaint response and to ensure that any outstanding issues are dealt with in a timely manner and this performance can be measured

14. PALS activity

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

The number of contacts in this respect, for the year 2023/24, with a comparison for previous years, is shown below.

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Improvement suggestions	112	62	66	28	37	31
Information	1262	1134	735	563	1216	966
Signposting	710	814	557	355	624	433
Total	2084	2010	1358	946	1877	1430

15. Lessons learned, and actions taken from complaints

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

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

There have been many actions from complaints this year across the divisions and some examples are detailed below:

Staff attitude and behaviours

- Medicine – matrons working a night shift to monitor behaviours of night staff
- Outpatients – Tthe Nursing team has created new staff standards that help everyone to contribute to a more caring culture
- Medicine and Surgery - continual roll out of appreciative inquiry (AI) and human factors training

Patient Care and treatment

- Surgery and Medicine - the monitoring of call bell placement through ward assurance audits
- Maternity - review and increase of staffing levels and support staff roles, to enable increased post-operative assistance with baby care
- Maternity - purchasing of new cots that swing over the mother's bed to make it easier to lift the baby in and out of the cot following a caesarean section
- Surgery – Ward 23 undertaking an improvement project focusing on the nutritional needs of patients
- Surgery – Ward 23 – during the Board Round meeting, urinary and bowel care has been added to the agenda, to ensure escalation, if required
- Medicine – Ward 15 - education sessions for the Nursing team regarding the administration of Zoladex
- Surgery and Medicine – completion of audits on ten occasions each month to monitor how staff are assessing and managing patient's pain. Action plans are created in response to audits and monitored by the Corporate team
- Neonates - thematic review of neonatal antibiotic administration
- Medicine - the Respiratory team have changed their practice to ensure that CT chest scans, of any patient being treated for cancer who has had Radio Frequency Ablation (RFA), are discussed with the Harefield Hospital team
- Medicine -

it is now the aim of the Endocrinology department to provide support, care, and cure for patients with thyroid eye disease, by offering reviews every 6 weeks by telephone or face to face appointments.

Communication

- Maternity – birth partners now able to stay overnight
- Gynaecology - to ensure that every patient receives a telephone call prior to results being sent via post or email. The aim of the communication will be to give context to the results and provide an opportunity for the patient to ask any questions they may have
- Maternity – review of the Induction of labour patient information leaflet to ensure the risks and benefits are clearly identified
- Medicine – Ward 22 to make available a reasonable and comfortable space available to families who are receiving bad news
- Core Clinical - Out of Hours Pharmacy list displayed prominently in ED so that staff can direct patients appropriately
- Surgery - improvement to appointments letters regarding telephone appointment to alert patients that their appointment may not be at the exact time given and to allow a 45-minute window
- Patient Services - the Admissions team have undertaken staff training, with amendments made to staff induction, to improve communication and overall professionalism of the service

15. Conclusion

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

The complaints process used at MKUH is aligned to local policy and national regulations and guidance and, as such, all complaints are encouraged and dealt with in a timely manner with an appropriate response being given. The themes and trends from complaints are considered when setting the priorities for the Trust in relation to patient experience.

Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 5 September 2024**
Report Title	Risk Management Report	**Agenda Item Number: 16**
Lead Director	*Kate Jarman, Director of Corporate Affairs*	
Report Author	*Paul Ewers, Senior Risk Manager*	

Introduction	The report provides assurance that the Risk Management process is being effectively managed.
Key Messages to Note	Please take note of the trends and information provided in the report. **Risk Appetite:** This is defined as the amount of risk the Trust is willing to take in pursuit of its objectives. The risk appetite will depend on the category (type) of risk.

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

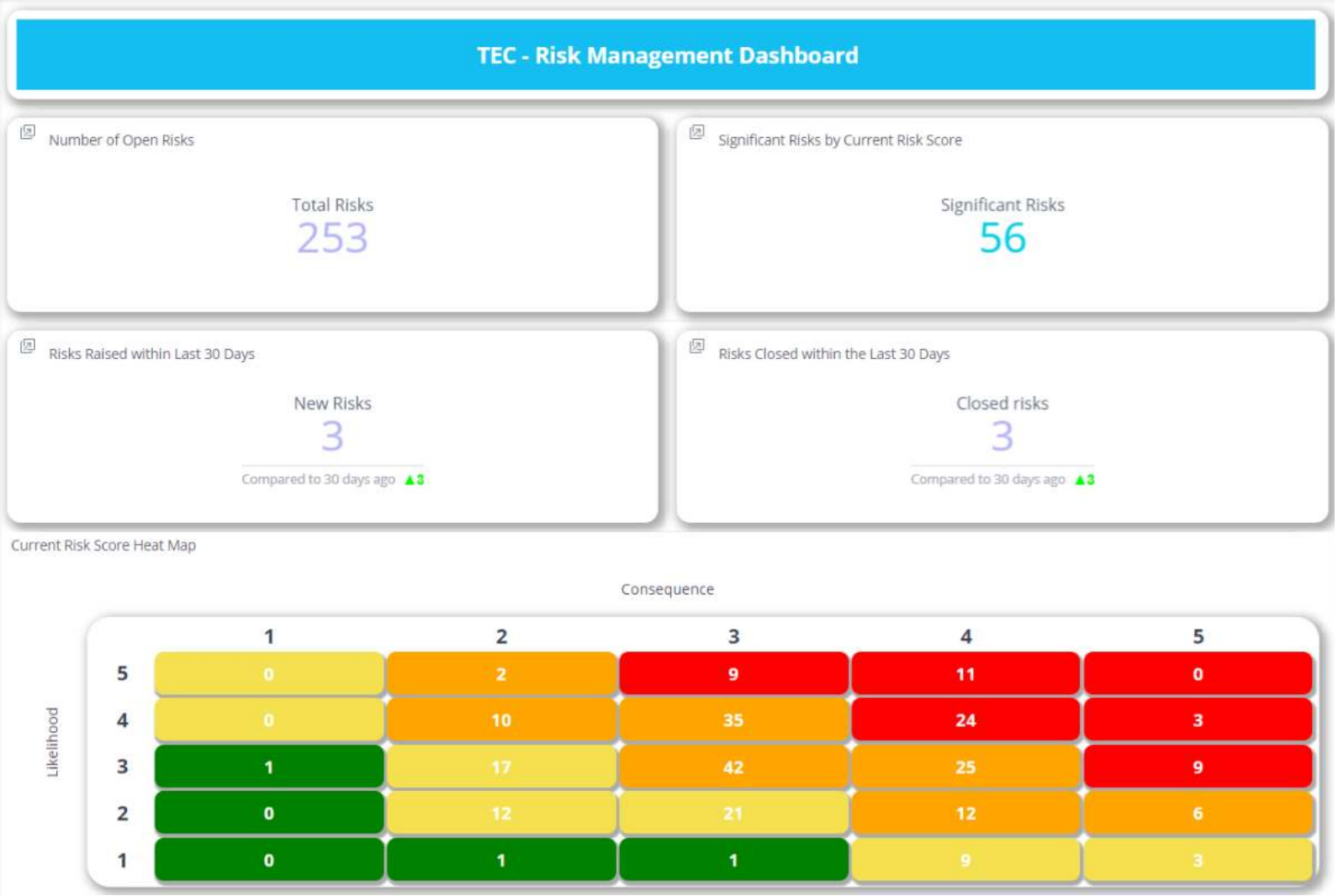
Note: The Risk Appetite statements are currently under review.

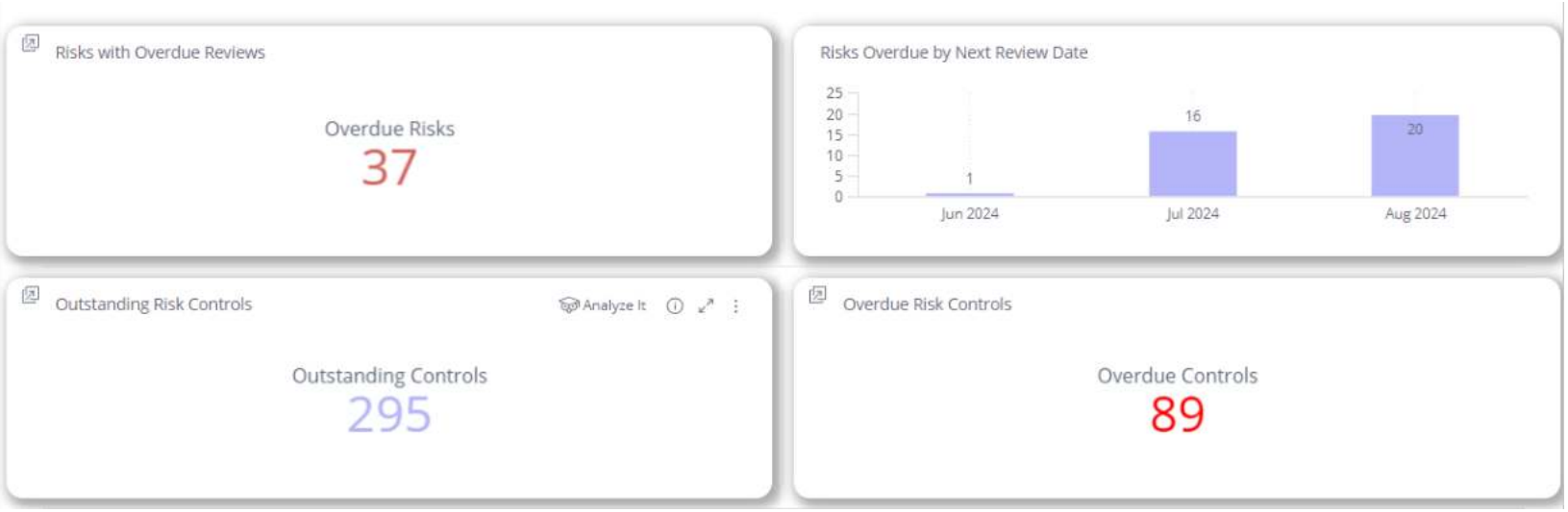
Recommendation *(Tick the relevant box(es))*	**For Information**	☐	**For Approval**	☐	**For Assurance** ☑

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

Report History	The Risk Report is an ongoing agenda item
Next Steps	*N/A*
Appendices/Attachments	*Corporate Risk Register* *Significant Risk Register*

Risk Management Dashboard (Radar):





Exception Reporting:

The above dashboard provides a summary of the key metrics to provide assurance that the risk management process is working as intended.

The key highlights are as follows:

1. The total number of risks remains quite static at around 250-260 risk. This shows that whilst risks are being identified and added to the Risk Register, a similar number of risks are being closed month on month.
2. There are 56 risk currently identified as significant (22%). The heat map shows that around half of the risks are graded as moderate harm. Therefore, around three quarters of the risks identified are either moderate or significant risks to the Trust objectives – therefore highlighting the importance of these being effectively managed.
3. There are currently 37 risks that are overdue their review date. Risks need to be reviewed frequently to ensure decision are being made using up to date / correct information.
4. Whilst there are a high number of risks overdue their review date, only 8 of these are more than 1 month overdue. It should be noted that most Risk Owners choose the last or first day of the month as the review date – resulting in the number of overdue being higher during this time. The current trend is that the number of overdue decreases across the month and increases again at the end of the month. This shows that whilst generally, risks are reviewed regularly, they do often fall outside of their review period. This is something that Risk Owners / Divisions need to tighten up.

5. There are 295 controls that have been identified and are in progress. This shows that when risks are identified, controls are being identified to mitigate the risk. However, of these 89 are past their due date. When reviewing their risk, Risk Owners must check the due dates of the controls and either close the control if they are complete (or no longer needed) or update the due date to a more appropriate date. This part of the risk management process needs significant work to bring ensure that the information around controls are up to date and relevant.
6. Following Internal Audit recommendations, a proposal has been made to the Education Board that Risk Management training is made mandatory for all staff bands 7 and above, with a 3 yearly renewal. Awaiting decision of approval following the August Education Board meeting. This should support staff understanding of the importance of the process and their role in ensuring risks are regularly identified, assessed, controlled and reviewed.

Recommendations:

1. Divisions/Corporate Department to ensure that their risks are being regularly reviewed in line with the Risk Management Framework. Risks graded 1-6 must be reviewed at least annually. Risks graded 8-25 must be reviewed at least monthly.
    a. All risks that are more than 1 month overdue their review to be updated by 30 September 2024.
    b. All risk less than 1 month overdue their review date to be updated by 31st October 2024.
2. Divisions/Corporate Departments to ensure that controls are reviewed and updated as part of reviewing each risk.
    a. All controls to be updated and either closed or their due dates extended by 30th November 2024.
3. Ongoing monitoring of risk and controls that are past their review dates at TEC through the monthly Risk Management report.

Meeting Title	**Trust Board in Public**	**Date: 5 September 2024**
Report Title	*Board Assurance Framework*	**Agenda Item Number: 17**
Lead Director	Kate Jarman, Chief of Corporate Services	
Report Author	Paul Ewers, Senior Risk Manager	

Introduction	This report is to provide assurance that the Board Assurance Framework (BAF) is being effectively managed.		
Key Messages to Note	The format of this report has been changed in order to make reporting on the BAF more succinct and make it easier to highlight key messages and concerns.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** [x]

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

Report History	Regular Committee cycle
Next Steps	*N/A*
Appendices/Attachments	*Board Assurance Framework*

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BAF Dashboard:

	Strategic Risk	Executive Lead	Inherent Risk (level of risk without controls)	Current Risk – Trend Over Time (level of risk Trust is currently exposed to)												Target Risk (level of risk deemed tolerable)	Risk Appetite	Treatment Strategy	Assurance Rating
				Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug				
1	Continued industrial action resulting in significant disruption to care/ service provision	Chief People Officer	12								9	9	9	9	9	3	Avoid	Tolerate	Positive Assurance
2	Insufficient capital funding to meet the needs of population we serve	Chief Financial Officer	25	20	20	20	20	20	20	20	20	20	20	20	20	10	Avoid	Treat	Negative Assurance
3	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	Chief Financial Officer	20	20	20	20	20	20	20	20	20	20	20	20	20	8	Cautious	Treat	Negative Assurance
4	Patients experience poor care or avoidable harm due to delays in planned care	Chief Operating Officer – Planned Care	25								20	20	20	20	20	10	Avoid	Treat	Inconclusive Assurance
5	Patients experience poor care or avoidable harm due to inability to manage emergency demand.	Chief Operating Officer – Unplanned Care	25								20	20	20	20	20	10	Avoid	Treat	Inconclusive Assurance
6	System inability to provide adequate social care and mental health capacity.	Chief Operating Officer – Unplanned Care	20								20	20	20	20	20	8	Avoid	Treat	Inconclusive Assurance

	Strategic Risk	Executive Lead	Inherent Risk (level of risk without controls)	Current Risk – Trend Over Time (level of risk Trust is currently exposed to)												Target Risk (level of risk deemed tolerable)	Risk Appetite	Treatment Strategy	Assurance Rating
7	Political instability and change	Chief Executive Officer	15								6	6	6	6	6	6	Cautious	Tolerate	Positive Assurance
8	If the pathway for patients requiring head and neck cancer services is not improved, then users of MKUH services will continue to face disjointed care, leading to unacceptably long delays for treatment and the risk of poor clinical outcomes	Chief Medical Officer	25	15	15	15	15	15	15	15	15	15	15	15	15	10	Avoid	Treat	Inconclusive Assurance
9	Insufficient staffing levels to maintain safety	Chief People Officer	15	10	10	10	10	10	10	10	10	10	10	10	10	5	Avoid	Treat	Inconclusive Assurance

Longer-term Risks: Seven longer-term risks have been identified.

1. Conflicting priorities between the ICS and providers
2. Lack of availability of skilled staff
3. Increasing turnover
4. Lack of time to plan and implement long-term transformational change
5. Long-term financial arrangements for the NHS
6. Growing/ageing population
7. A pandemic

Proposed New Risks: In addition to the above risks, it is proposed that the following risks are added to the BAF. These are to be reviewed and considered as part of a deep dive into the BAF in October 2024:

1. Deteriorating quality of the estate
2. Data/Cyber Security

Exception Reporting:

The above dashboard provides a summary of the risks on the Board Assurance Framework.

The key highlights are as follows:

- SR3. Risk controls and actions updated to reflect current position. FIC to continue to monitor risk cautiously. There is potential for the risk to increase to 5x5=25 risk over the next quarter. To remain at 20 currently.
- Internal Audit have requested that actions on controls and actions on assurance should have expected completion dates, to ensure that they are SMART actions. Work has started on adding this information into the BAF document.
- Internal Audit have requested that risks to all Strategic Objectives should be considered and potentially added to the BAF.

Recommendations:

1. On the next round of updating the BAF risks, the expected completion dates should be considered and added by each of the actions on control and actions on assurance.
2. At the Board Seminar / Deep dive in October 2024, the board should consider whether there are any risks that need adding to the BAF relating to the Trust strategic objectives that do not have an associated BAF risk.
3. The proposed two new risks (Deteriorating quality of estate and Data/Cyber security) to be reviewed at the Board Seminar on the BAF in October 2024.

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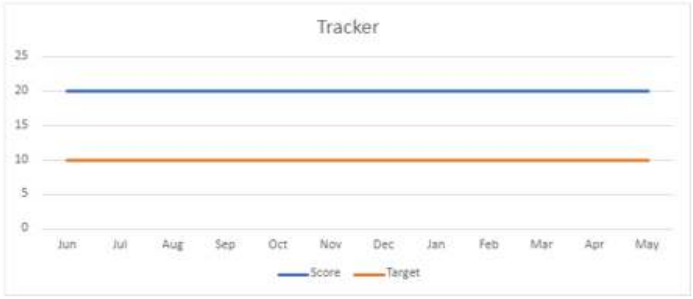
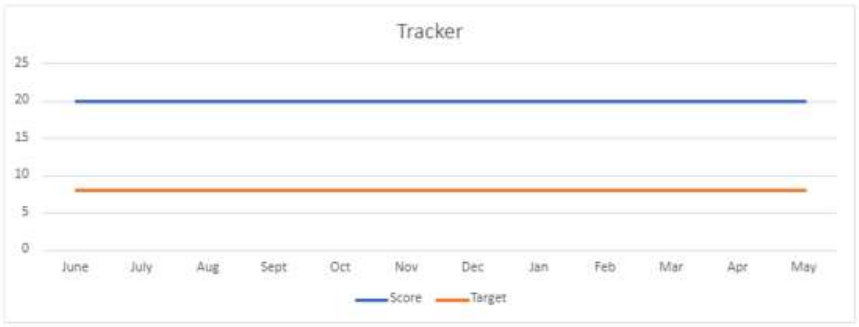
Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 5 September 2024**
Report Title	Finance & Investment Committee Assurance Report	**Agenda Item Number: 18**
Committee Chair	**Gary Marven,** Non- Executive Director & Chair of the Committee	
Report Author	**Gary Marven,** Non- Executive Director & Chair of the Committee	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Finance & Investment Committee since the last Board held in public.		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** X

Strategic Objectives Links *(Please delete the objectives that are not relevant to the report)*	*1. Spending money well on the care you receive* *2. Employ the best people to care for you* *3. Expanding and improving your environment* *4. Innovating and investing in the future of your hospital*

1. Board Assurance Framework

Strategic Risk 2	**Insufficient capital funding to meet the needs of population we serve**						
Lead Committee	Finance & Investment Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Chief Financial Officer	**Consequence**	5	5	5	**Risk Appetite**	Avoid
Date of Assessment		**Likelihood**	5	4	2	**Risk Treatment Strategy**	Treat
Date of Review	May 2024	**Risk Rating**	25	20	10	**Assurance Rating**	Negative Assurance
Linked Trust Objectives	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 7. Spending money well on the care you receive 9. Expanding and improving your environment 10. Innovating and investing in the future of your hospital						
Linked Corporate Risks	RSK-305 RSK-526						
Trend							

Strategic Risk 3	**If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.**						
Lead Committee	Finance & Investment Committee	**Risk Rating**	**Inherent**	**Current**	**Target**	**Risk Type**	Financial
Executive Lead	Chief Financial Officer	**Consequence**	4	4	4	**Risk Appetite**	Cautious
Date of Assessment	March 2023	**Likelihood**	5	5	2	**Risk Treatment Strategy**	Treat
Date of Review	May 2024	**Risk Rating**	20	20	8	**Assurance Rating**	Negative Assurance
Linked Trust Objectives	1. Keeping you safe in our hospital 2. Improving your experience of care 3. Ensuring you get the most effective treatment 7. Spending money well on the care you receive 9. Expanding and improving your environment 10. Innovating and investing in the future of your hospital						
Linked Corporate Risks							
Trend							

2. Committee Discussions and Decisions

The following decisions were made at the committee held on **27 August 2024**

Agenda Item	Decision Made	Comments
Capital programme update	The Committee noted the update	In the light of the NHP funds approved (and the Oak Ward case) it would be helpful to understand what the proposed end-state ward configuration will be going forward when all capacity is complete (and what this looks like during the interim period). Also, how this aligns with predicted patient demand - escalation to board
Oak Wards Business Case	Approved to forward to Board	This case was onward recommended to Board. It was noted that the case only sets out the capital costs and the revenue costs of running the building. A further business case, to support the operating model costs this build will incur, needs to be brought forward to Oct/Nov Board. The capital risks, namely resource availability over future years (given the CDEL allocation is under pressure) was noted and the options to mitigate discussed.
Heat network de-carbonisation	Approved to forward to Board	This case, in essence, and under the current energy tax regime, would see an increase in operational costs incurred to achieve our green objectives. The option on the table, which involves an external capital grant, will offset some unavoidable capital replacement costs

		in addition to decarbonisation benefits, the priority we are giving this, at a busy time for the hospital and weighing up the increased revenue costs that will result, as compared to the potential future benefits (inclusive of potentially reduced CDEL costs) all need further discussion.
Financial report and Cash flow report	Noted	Whilst we are in a challenging environment, with a 6% efficiency target, we saw a £0.5m improvement in our YTD variance to plan from last month. Our YTD deficit now stands at £4.3m, which in terms of direction of travel, is pleasing and evidences the focus on these targets. Against this improved position, the Committee deep dived on the performance of the core clinical division which is significantly behind plan and the need to implement an improvement plan along with discussion for what support they need to be successful. It should be noted that in general, and as highlighted on the BAF, our agreed plan of reaching a breakeven position by year end has many risks attached to it. The Committee discussed in detail a risk regards elective recovery fund (ERF) activity taking place in SDEC and how changes in how this is recognised could impact both profit and cash. The Committee also noted the wider financial performance of the ICS and the resultant risk that regulatory action may ultimately result given the system deficit position. This would limit management ability to take financial decisions independently and result in additional oversight upon both the system and Trust..
Efficiency report	Noted	The committee noted the very impressive work underway to deliver necessary financial efficiency, supported by PA consultancy. This has put in place a professional programme management structure, to drive both divisional efficiencies and also identifies cross divisional efficiencies. The important point here is the identification of recurring savings
Performance report	Noted	Challenges remain and the discussion focused on the zero target for over 65 day waits
Dermatology contract	Approved to forward to Board	The Committee approved a procurement approach to delivering this contract, following very limited response to recent market engagement exercise. A discussion around how the Trust could avoid similar situations in the future, and how priority had been given to service needs in this process, too place. The Committee felt satisfied with clarification on these matters.

Radiology reporting contract	Approved	New contract at reduced costs We need to consider how important this is, i.e. what priority we should place on finding a new or more competitive process, given that the performance of the current supplier is satisfactory

3. Assurance

The Chair and Non-Executive Directors were assured that:

- As noted in comments

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

The following items have been recommended to be escalated to the Trust Board for further discussions and approvals:

- As noted in comments

5. Recommendation

The Board are invited to note the Finance Committee Assurance report.

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Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 5 September 2024**
Report Title	Audit Committee Assurance Report	**Agenda Item Number:**
Committee Chair	Mark Versallion, Non- Executive Director & Chair of the Committee	
Report Author	Kemi Olayiwola, Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Audit Committee since the last Trust Board held in public.		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** X

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

1. Committee Discussion and Decision

The following decisions were made at the Audit Committee held on **15 July 2024**

Agenda Item	Decision Made	Comments
Internal Audit Progress Report	The Committee noted the report	It was highlighted that changes in Internal Audit Standards effective January 2025 would impact the corporate sector more than the public sector, however, there were no significant changes for the Trust The Trust was required to update its procurement processes accordingly. The Finance and Investment Committee would monitor these changes. There was significant reduction in overdue actions, currently standing at four, indicating effective focus and process refinement.

Business Continuity Audit	The Committee noted the Business Continuity Audit	An audit of Business Continuity for the Trust had been undertaken which highlighted areas of the organisation where further work was required to ensure fully signed off plans were in place. The Trust have committed to addressing this fully.
Counter Fraud Progress Report	The Committee **noted** the report	It was highlighted that two fraud allegations were received this year, both closed, and a significant ongoing case from the previous year leading to court, showcased the Trust's active measures in fraud prevention and legal pursuits
Financial Controller's Report	The Committee approved reported write offs and noted report	It was noted that more robust debt recovery strategies were being considered to reduce salary overpayments and overseas patients defaulting on owed monies.
Waiver Report	The Committee **noted** the report	The report highlighted a significant reduction in the number of waivers, which was reflective of the Trust's commitment to improving procurement practices and compliance
Compliance Reports	The Committee **noted** the report	There were no further comments.
Board Assurance Framework (BAF)	The Committee **noted** the report	The Committee reviewed the BAF, noting the addition of two new risks for inclusion on the BAF for 2024/25 which had been approved by Board on 4 July 2024
Committee Evaluation Report 2024/25	The Committee discussed the report	Further discussions would be had on the proposed actions.

2. Assurance

The Committee were assured that the Trust had successfully reduced overdue actions, indicating effective focus and process refinement

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

There were no escalations from the committee to the Trust Board.

Recommendation
• The Board are invited to NOTE the report.

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Meeting Title	**TRUST BOARD (PUBLIC)**	**Date: 5 September 2024**
Report Title	Workforce Development & Assurance Committee Assurance Report	**Agenda Item Number: 18**
Committee Chair	Heidi Travis, Non-Executive Director & Chair of the Committee	
Report Author	Kemi Olayiwola, Trust Secretary	

Introduction	The purpose of the report is to provide an update to the Trust Board on the activities of the Workforce Development & Assurance Committee since the last Trust Board held in public.		
Key Messages to Note	The Trust Board is invited to NOTE the report.		
Recommendation *(Tick the relevant box(es))*	**For Information** ☐	**For Approval** ☐	**For Assurance** [x]

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

1. Committee Decision Log

The following decisions were made at the Workforce Development & Assurance Committee held on **8 July 2024**

Agenda Item	Decision Made	Comments
Board Assurance Framework	The Committee **noted** the update on the Board Assurance Framework.	The industrial action risk held on the BAF was discussed. It was highlighted that there was a risk of further industrial action due to the potential impact of the rebanding discussions of Band 2 to Band 3 with Unions.
Workforce Risk Register	The Committee **noted** the Workforce Risk Register	It was noted that there would be a reduction of scoring to the Manual Handling risk (RSK-490) due to the successful recruitment and induction of a competent person in the role

Workforce Strategy	The Committee **noted** the Workforce Strategy	The committee were updated on the strategies to reduce the use of temporary staffing and the initiatives taken to identify employee's lived experiences to better inform the Equality, Diversity & Inclusion (ED&I) action plans.
Objectives Update	The Committee **noted** the Objectives Update	The Committee noted the committee's success of monitoring the objectives. The Committee were assured of the inclusion of Allied Health Professionals (AHPs) in the Professional Advocate scheme.
Gender Pay Gap	The Committee **noted** the update on the Gender Pay Gap Annual Report and **approved** the publication of the report onto the Trust's website and the upload of the data onto the national reporting framework.	The Committee acknowledged the work undertaken to drive the changes within the Trust and confirmed their confidence from the recommendations made in the report.
NHS Staff Survey	The Committee **noted** the results of the NHS Staff Survey	Future plans for increased engagement in the survey were shared with the committee. Good discussions regarding violence and aggression by patients were had, and it was noted that incidents had also increased in other sectors, including retail. Training and policies had already been implemented within the Trust, however incidents were increasing. The committee noted the gap in capacity to continue to train and develop staff to deescalate situations and the reduced availability to offer welfare support for staff.
Employee Relations	The Committee **noted** the Annual Employee Relations Report.	The Committee discussed the increase of flexible working requests and the processing of said requests.
Revalidation and Job Plans	The Committee **noted** the Revalidation and Job Plans report and **approved** the escalation of the report to the Trust Board.	There were no other comments.
WDAC Self Evaluation Report	The Committee **noted** the Workforce and Development Assurance Committee Self Evaluation Report and	It was highlighted that overall, the rating and comments received from Committee members and attendees demonstrated a positive assurance

	approved the escalation of the report the Trust Board.	response to the Committee's functions and performance

2. Assurance

- (Comments above)

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

- Revalidation and Job Planning Report
- The Workforce and Development Assurance Committee Self Evaluation Report

4. Recommendation

- The board are invited to note the report.

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TRUST BOARD MEETING IN PUBLIC

Forward Plan 2024-25

	Agenda Item	Lead	Purpose	Frequency Paper(P)/Verbal (V)	Seminar 04-Apr-24	Formal 02-May-24	Seminar 06-Jun-24	Formal 04-Jul-24	Formal 05-Sep-24	Seminar 03-Oct-24	Formal 14-Nov-24	Seminar 05-Dec-24	Formal 09-Jan-25	Seminar 06-Feb-25	Formal 06-Mar-25
1	Apologies	Chair	Receive	Standing Item (V)		■		■			■		■		■
2	Meeting Quorate	Chair	Note	Standing Item (V)		■		■			■		■		■
3	Declaration of Interests	Chair	Note	Standing Item (V)		■		■			■		■		■
4	Minutes of the previous meeting	Chair	Approve	Standing Item (P)		■		■			■		■		■
5	Action Tracker	Chair	Note	Standing Item (P)		■		■			■		■		■
6	Chair's Report	Chair	Information	Standing Item (V)		■		■			■		■		■
7	Chief Executive's Report	Chief Executive	Receive and Discuss	Standing Item (V)		■		■			■		■		■
8	Patient Story/Staff Story (Rotational)	Chief Nursing Officer	Receive and Discuss	Standing Item (P)		■		■			■		■		■
9	Nursing Workforce Update	Chief Nursing Officer	Receive and Discuss	Standing Item (P)		■		■			■		■		■
10	Performance Report	Chief Operating Officer	Receive and Discuss	Standing Item (P)		■		■			■		■		■
11	Finance Report	Chief Finance Officer	Receive and Discuss	Standing Item (P)		■		■			■		■		■
12	Workforce Report	Chief People Officer	Receive and Discuss	Standing Item (P)		■		■			■		■		■
13	Serious Incident Report	Chief Medical Officer/Chief Corporate	Receive and Discuss	Standing Item (P)		■		■			■		■		■
14	Objectives Update	Chief Executive	Assurance Receive and Discuss	(P)									■		
15	Equality, Diversity & inclusion (ED&I) Update	Chief People Officer	Assurance Receive and Discuss	(P)					■						
16	CNST Maternity Incentive Scheme and Board Assurance Framework	Chief Nursing Officer	Assurance Receive and Discuss	(P)									■		
17	Progress update – 2024/25 Quality Priorities	Chief Corporate Services Officer	Assurance Receive and Discuss	(P)									■		
18	Declaration of Interests Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Annually (P)		■									
19	Maternity Patient Survey 2024 interim report	Chief Nursing Officer	Assurance Receive and Discuss	(P)		■									
20	Annual Claims Report	Chief Medical Officer	Assurance Receive and Discuss	Annually (P)		■									
21	Falls Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	Annually (P)		■									
22	Freedom to Speak Up Guardian Report	Chief People Officer	Assurance Receive and Discuss	(P)				■					■		

23	Pressure Ulcers Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	Annually (P)												
24	Green Plan Update	Chief Finance Officer	Assurance Receive and Discuss	(P)												
25	Green Plan Update (C/F from July 2024)	Chief Finance Officer	Assurance Receive and Discuss	(P)												
27	Mortality Update	Chief Medical Officer	Assurance Receive and Discuss	(P)												
28	Safeguarding Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	Annually (P)												
	Research & Development Annual Report	Chief Medical Officer	Assurance Receive and Discuss													
30	Emergency Preparedness, Resilience and Response Annual Report	Chief Operating Officer	Assurance Receive and Discuss	(P)												
31	Annual Complaints Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Annually (P)												
32	Annual Patient Experience Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Annually (P)												
33	Patient Safety Incident Response Framework, PSIRF – Policy and Plan	Chief Corporate Services Officer	Assurance Receive and Discuss	(P)												
34	Antimicrobial Stewardship - Annual Report	Chief Medical Officer	Assurance Receive and Discuss	Annually (P)												
35	Infection Prevention and Control Annual Report	Chief Nursing Officer	Assurance Receive and Discuss	(P)												
36	Patient Experience Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Standing Item (P)												
37	Maternity Assurance Group Update	Chief Nursing Officer	Assurance Receive and Discuss	Standing Item (P)												
	Update to the Terms of Reference of the Board and its Committees	Chief Corporate Services Officer	Assurance Discuss and Approve	Annually (P)												
38	Summary Reports from Board Committees	Chairs of Board Committees	Assurance and Information	Standing Item (P)												
39	Significant Risk Register Report	Chief Corporate Services Officer	Assurance Receive and Discuss	Standing Item (P)												
40	Board Assurance Framework	Chief Corporate Services Officer	Assurance Receive and Discuss	Standing Item (P)												
41	Trust Seal	Chief Corporate Services Officer	As required	(P)												
42	Forward Agenda Planner	Chair	Administration and Closing Information	Standing Item (P)												
43	Questions from Members of the Public	Chair	Administration and Closing Receive and Respond	Standing Item (V)												
44	Motion To Close The Meeting	Chair	Administration and Closing Receive	Standing Item (V)												
45	Resolution to Exclude the Press and Public	Chair	Administration and Closing Approve	Standing Item (V)												
SEMINAR SCHEDULE																
	Annual Risk Seminar	Chief Corporate Services	Risk Management													
	Board Assurance Framework (BAF) Review	Chief Corporate Services	Assurance													
	Collaborative partnership/s—with whom and for what services. Future plans	Chief Executive	Assurance													
	The Trust role around, and contribution to, population health management/Place	Chief Executive	Assurance													
	Annual Objectives Review	Chief Executive	Assurance													
	Annual Strategy Review	Chief Executive	Assurance													

	Strategic links with community groups/organisations/ businesses	Chief Executive	Assurance												
	The Trust's representations on the BLMK ICB and ICP, and the implications thereof	Chief Executive	Assurance												

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TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 05 September 2024

Questions from Members of the Public

Heidi Travis
Chair

Verbal/Discuss

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TRUST BOARD IN PUBLIC

Virtual/Teams

Thursday, 05 September 2024

Motion to Close the Meeting

Heidi Travis
Chair

Verbal/ Receive