Appendix G

Milton Keynes University Hospital NHS Foundation Trust

QUALITY REPORT 2017-2018

Part 1: The Quality Account

1.1 Introduction

Milton Keynes University Hospital NHS Foundation Trust (referred to as 'MKUH' or 'the Trust') is a district general hospital providing a broad range of general medical and surgical services, including A&E, maternity and paediatrics. We continue to develop our facilities to meet the needs of our rapidly growing local population.

The Trust provides services for all medical, surgical, maternity and child health emergency admissions. In addition to delivering general acute services, the Trust increasingly provides more specialist services, including cancer treatments, neonatology, and a suite of medical and surgical specialisms.

We aim to provide quality care and the right treatment, in the right place, at the right time. The Trust's strategic objectives are focused on delivering quality care, with the first three objectives being:

1. Improving patient safety
2. Improving patient experience
3. Improving clinical effectiveness

To support our framework for quality we have a rigorous set of standards for monitoring our performance against local and national targets, which helps us to identify and address any issues as they arise.

We are proud of our professional, compassionate staff and of our strong relationships with local stakeholders. The involvement of patients, the public, governors, Healthwatch, and health and care system partners is integral to our development.

Our governors are involved throughout the year in monitoring and scrutinising our performance. The governors continue to demonstrate their commitment to fulfilling their role as the elected representatives of patients and the public, through their direct contacts with members of the community, as well as their participation in a range of community forums, including Milton Keynes Healthwatch and various patient participation groups. An elected governor also attends, in an observer capacity, meetings of the Quality and Clinical Risk Committee, which monitors the performance of the hospital against quality indicators and delivery of quality priorities, including those set in the Quality Account.

During the year, we have continued to actively engage with the Milton Keynes Council Health and Adult Care Select Committee and the Health and Wellbeing Board on quality matters concerning the Trust as an acute hospital and those affecting the wider health and care system.

This Quality Report is an annual report to the public about the quality of our services; it outlines our measures for ensuring we continue to improve the quality of care and services we provide; and outlines progress and achievements against previous quality priorities.

Specifically the purpose of the Quality Report is to enable patients and their carers to make well informed choices about their providers of healthcare; the public to hold providers to account for the quality of the services they deliver; and Boards of NHS provider organisations to report on the improvements to their services and to set out their priorities for the following year.

One of the requirements in compiling the Quality Report for the previous financial (2017/18) is to select at least three quality priorities for the year ahead (2018/19). These priorities are included in Part 2 of the Quality Report.

In selecting quality priorities, the following criteria should be satisfied:

- The quality priority should be determined following a review of the quality of service provision
- The quality priority should reflect both national and local indicators
- The quality priority should be aligned with the three domains of quality: patient safety, clinical effectiveness and patient experience.

Once agreed the Quality Report must indicate how the priorities will be met, monitored, measured and reported by the Trust. The Quality Report provides an evaluation of progress in meeting the quality priorities set for 2017/18 and gives a general overview and evaluation of how well the Trust has performed across a range of quality metrics throughout the year.

1.2 Statement on quality from the Chief Executive

It is my privilege to introduce this year's Quality Account for Milton Keynes University Hospital NHS Foundation Trust.

This important document gives us the opportunity to reflect on all we have achieved in improving the quality of care provided to our patients during 2017/18. It also allows us to identify where we will focus our efforts next year in order to make the care and experience we provide as safe, as positive and as effective as it can be.

Each year, we set out objectives as a hospital and each year our top three objectives are: improving patient safety, improving patient experience and improving clinical effectiveness. These three objectives remain at the heart of everything we do and everything we are here to deliver, every day. That is the case for every single one of the thousands of people we care for, every single year.

It has been a very exciting year of developments at the hospital. Once again we have continued to invest in the development of our staff, our services and the estate itself with the aim of further improving both quality of care and the availability of services to the people of Milton Keynes and surrounding areas.

In terms of developing our estate to support better patient care and experience, the highlight of the year has been the opening of our new main entrance, a multi-million pound project that offers improved access to the hospital site and includes comfortable waiting areas, dedicated offices for our PALS (Patient Advice and Liaison Service) and Age UK, as well as food and drink outlets.

In February 2018, we welcomed HRH the Duke of York as he officially opened the new Academic Centre on the Trust site. This building is a result of our partnership with the University of Buckingham Medical School, who funded its development. It is already in use and is providing an outstanding education resource to train medical students, doctors, nurses and health professionals working across the hospital.

In order to maintain the level of car parking provision, we are currently building a second multi-storey car park on site. This is due for completion in May. Immediately after that opens, more contractors will arrive on site to begin work on what will become our dedicated Cancer Centre. This will locate oncology, clinical haematology and cancer-related chemotherapy under one roof. The development, which is due to open toward the end of 2019, will mean that the hospital can offer improved cancer services, help increase capacity, establish new emergency care pathways and support the future demand for cancer services in Milton Keynes.

In March 2018, we completed the building of our new dedicated paediatric Emergency Department. This means children needing emergency care have a separate entrance and waiting area, so that parents and carers bringing in sick children do not have to be processed through the adult Emergency Department. It offers a bright, colourful and welcoming environment to young people and their families while they wait to be assessed and treated.

As part of our ongoing plans to contribute to improved public and staff health and wellbeing, the Trust became an entirely smoke-free site in October 2017, coinciding with national No Smoking Month. Smoking of all forms (tobacco, e-cigarettes and vaping) is prohibited in all areas, including public and staff car parks. This move represents a positive step towards creating a healthier environment and reflects our ethos as an organisation that we are committed to providing all staff and visitors with the information and tools they need to live a healthier lifestyle. A major public awareness campaign supported this, with the hospital giving smoking ‘a red card’. We continue to work with the Stop Smoking Service at Milton Keynes Council to work on the ways we can help staff and patients to reduce or stop smoking altogether.

A phenomenal amount of ground work has been going on behind the scenes in preparation for the launch, in May 2018, of eCARE, our new electronic patient records system. This digital system will significantly improve the way patients are seen and treated. It will allow our staff to treat patients more effectively by providing them with easier access to up to date information that can be shared in real time across all departments. The system will be capable of suggesting plans of care, supporting clinical decision-making and ensuring that patients are receiving the treatment they require. eCARE is more than just a computer system, it is a new way of working – giving staff access to improved up to date information so they can deliver safer and more efficient care.

Demand on the hospital’s services continued to increase during 2017/18. We received 2.1% more GP referrals than had been planned for, and demand on the Emergency Department was 1.1% higher than in 2016/17, with increasingly complex and acutely unwell patients. The impact of the increase in demand has been that the Trust has accommodated a growing number of emergency admissions but accepted 4.1% fewer elective admissions than it did in 2016/17.

The increase in demand for our services has had an impact on our performance in the latter half of the year against the national standard for consultant-led Referral to Treatment Waiting Times. This remains an area of focussed effort for the Trust.

Our quality metrics are published at every public Board meeting so that any member of the public can see and scrutinise our performance against a range of national, internal and peer-benchmarked metrics. This quality and performance dashboard includes national access targets, as well as quality indicators like mortality measures, numbers of serious incidents and never events, rates of infection and pressure ulcers and more.

We are committed to continuing to improve the quality of the care we provide. Each year we challenge ourselves to do better so that our patients get the best possible care, treatment and experience whilst in our care or using our services. This will continue to be our priority in 2018/19.

We have been working during 2017/18 on the actions that need to be taken to enable the trust to meet the clinical standards developed in 2013 for seven day services within hospitals. The steps that need to be taken to meet the requirements of the four priority standards have been identified and the additional investment that will be required has been quantified. Those interventions that have been identified as first order priorities are to be progressed, subject to approval through the trust's normal governance mechanisms, during the course of 2018/19.

1.3 Statement of Assurance

There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

During the year, we have continued to be actively engaged with the Milton Keynes Council Health and Adult Care Select Committee and the Health and Wellbeing Board on subjects of importance to the community.

This report also outlines our measures for assuring and sustaining performance for the future, recognising that there are areas requiring improvement

Joe Harrison
Chief Executive
May 2018

Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for Improvement in 2018/19

This section of the Quality Report describes the areas we have identified for improvement in 2018/19. These priorities have been shared with and agreed by our Board of Directors (Trust Board) and Council of Governors – a body made up of elected members of staff, members of the public and nominated stakeholder representatives.

Priorities for 2018/19:

1. Improving patient safety through the effective management of the World Health Organisation (WHO) surgical checklist
2. Improving patient experience by delivering the Gold Standard Framework for end of life care
3. Improving clinical effectiveness by improving processes in the Outpatients Department

2.1.1 Priority 1: World Health Organisation (WHO) Checklist (Patient Safety)

2.1.1.1 Description of the priority

We will review our systems for monitoring compliance against the World Health Organisation (WHO) surgical safety checklist in our operating theatres to make sure that the checklist is completed on every occasion. This will support our drive to ensure that the environment and culture within theatres places patient safety front and centre.

2.1.1.2 Why have we selected this as a priority?

The central tenet of medicine is ‘first, do no harm’. Many of the interventions which we undertake in modern healthcare are complex and therefore prone to error. Two fundamental steps in maximising the safety of complex processes in medicine are standardisation and communication.

The WHO surgical safety checklist supports both standardisation of practice in the theatre environment and improved teamwork and communication.

2.1.1.3 What is our past performance in this area?

The WHO surgical safety checklist is completed in a very high proportion of relevant cases (>98%). However, the completion of the checklist does not in itself tell us

about the safety culture within theatres and the degree to which standardisation and communication are optimised.

2.1.1.4 How will we monitor and measure our performance in 2018/19?

- We will revise and agree the methodology for quantitative reporting in relation to the use of the WHO surgical safety checklist.
- We will work with the regional Patient Safety Collaborative and others to design a mechanism through which we can obtain regular objective feedback about the conduct of the checklist and our overall safety culture
- We will establish a working party, a sub-group of the Theatres Improvement Group, to look at measures to optimise patient safety in the theatre environment
- We will adopt 'Greatix', a technique known as appreciative enquiry, in order to ensure that we learn from best practice within the organisation
- We will invest in our theatres environment to improve 'safety by design'
- We will work with colleagues outside the surgical environment to ensure that other procedures also adopt best practice in relation to checklists and communication

2.1.1.5 How will we report our progress against achieving this priority?

We will provide a detailed narrative report on our progress against the goals set out above in our 2018/19 Quality Account in June 2019. We will also report progress to the Clinical Quality Board and the Quality and Clinical Risk Committee (a sub-Committee of the Trust Board) throughout the year.

2.1.2 Priority 2: We will deliver the Gold Standard framework for end of life care

2.1.2.1 Description of the priority

National surveys suggest that people would prefer to die outside of hospital, but currently half of all patients who die in Milton Keynes die in hospital. Recent research (Clark 2014) shows that a third of all hospital inpatients are in the last year of their life and one in ten will die during their current admission. Many of these patients have repeated lengthy hospital admissions and the goals of treatment are sometimes unclear or unrealistic – adding to patient and carer distress. One reason for the unclear treatment goals, repeated admissions and people not dying where they would wish to is a lack of advance care planning.

2.1.2.2 Why have we selected this as a priority?

Nationally there is a drive to improve end of life care and to empower all staff with the tools and knowledge they need to make the end of a patient's life comfortable, dignified and in accordance with their wishes. This approach – of treating patients with compassion and having open and honest conversations about their care and their goals or wishes – is an important priority.

The Gold Standard Framework is a programme that has been established for over 15 years. The programme involves staff in the community, nursing homes and in

hospital settings, with the aim of improving the care of patients who are in their last year of life. The programme includes teaching and on-going support; and empowers staff to identify people in the last year of life and more advanced care planning discussions. This enables better care through proactive management and empowers patients as equal partners in planning their care and treatment.

The programme enables staff to be confident in having discussions about individual needs, wishes and preferences, not just as a one off event, but as part of the culture of care they provide.

Evidence from other hospitals undertaking the programme shows that following the Gold Standard Framework teaching, more patients are offered Advance Care Planning (ACP) discussions - 95% of patients on hospital wards, thought to be in the last year of life, who have completed the Gold Standard Framework programme were offered an ACP and 35% completed them. Staff who completed the programme felt more confident having Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) conversations and more patients were shown to have a DNACPR decision recorded.

The Gold Standard Framework improves coordination across care sectors and communication with patients and carers. Many GP practices across Milton Keynes have a Gold Standard Framework register and this programme will allow staff to use a common language across care settings.

2.1.2.3 What is our past performance in this area?

There were 30 complaints about end of life care at the hospital between January 2017 and January 2018. Common themes include poor communication and a lack of compassion and dignity.

Preferred place of death (a measure of advance care planning) is poorly documented – a snap shot audit of dying patients known to the Hospital Palliative Care Team in August 2017 showed that only 18 of 37 patients audited had this recorded.

2.1.2.4 How will we monitor and measure our performance in 2018/19?

There are a number of auditable and measurable key performance indicators that will help to assess the impact of Gold Standard Framework training including:

- Improved identification of patients in the last year of life and improved care in this period of time
- Improvement in staff confidence in caring for people in the last year of life, both from a care and communication point of view
- Improvement in discussing and recording DNACPR decisions
- Improvement in recording and achieving preferred place of care /death
- Increased number of patients who have a treatment escalation plan completed during their hospital admission

2.1.2.5 How will we report our progress against achieving this priority?

We will provide a detailed narrative report on our progress against the goals set out above in our 2018/19 Quality Account in June 2019. We will also report progress to the Clinical Quality Board and the Quality and Clinical Risk Committee (sub-Committee of the Trust Board) throughout the year.

2.1.3 Priority 3: Improving Outpatients (Clinical Effectiveness)

2.1.3.1 Description of the priority

The Outpatients Department is the busiest part of the hospital, seeing hundreds of thousands of patients every year. There is a real opportunity to improve both effectiveness of outpatient clinics and the experience our patients have of the service.

In selecting this as an improvement priority, we are setting out to do the following:

- Make sure that our patients know why they have an outpatient appointment and how to get the most benefit from that appointment
- Reduce the number of outpatient appointments cancelled or rescheduled by the hospital
- Reduce the length of time patients wait for their next appointment (beyond the timeframe recommended by medical staff when previously seen in clinic)
- Improve how we utilise our outpatient clinics, time and clinical staff to make sure we are as efficient and productive as possible
- Enable patients to do more to manage their own outpatient appointments – including the use of on online (digital) patient portal

2.1.3.2 Why have we selected this as a priority?

The Outpatients Department sees the most patient 'contacts' throughout the year – hundreds of thousands of patients visit clinics every year, and for some it is the only experience of the hospital they will have. Making sure patients who attend outpatient clinics have a positive experience; and that we use this valuable clinical resource efficiently and effectively, is a vital part of providing high quality health and care to local people.

2.1.3.3 What is our past performance in this area?

- In 2017/18, we cancelled or rescheduled over 30,000 outpatient attendances.
- In April 2017, over 13,000 patients were waiting longer than we would have wished for their follow-up appointment, having previously been seen in clinic.
- Five or more outpatient rooms per day tend to lie empty as room cancellations have not been made in a timely way that enables the room to be used by another clinician/ clinic.

2.1.3.4 How will we monitor and measure our performance in 2018/19?

1. We will agree standard operating procedures in all major outpatient specialties to improve consistency for patients seen in outpatients on an ongoing follow-up basis.

2. We will reduce the number of outpatient appointments cancelled or rescheduled by the hospital by 25% during 2018/19.
3. We will halve the number of patients waiting longer than expected for their follow-up appointment (having previously been seen by a clinician in an outpatient clinic).
4. We will define and monitor an agreed performance metric in relation to clinic utilisation (i.e. how efficient and productive our clinics are).
5. We will put in place a revised clinic administrative structure, including access to an online portal for patients to review and modify their own clinic appointments in at least three specialties.

2.1.3.5 How will we report our progress against achieving this priority?

We will report against our progress against to goals above in our 2018/19 Quality Account in June 2019. We will also report progress to the Clinical Quality Board and the Quality and Clinical Risk Committee (sub-Committee of the Trust Board) throughout the year.

2.2 Our Performance against Priorities for Improvement in 2017/18

In this section we set out the priorities for improvement included in last year's Quality Account (for the financial year ending in March 2017) and how we performed against them throughout the year.

The priorities for improvement for 2017/18 as set out in the 2016/17 Quality Account were:

1. Improving the management of patients with sepsis
2. Improving our arrangements for reducing stillbirths and neonatal deaths (Saving Babies' Lives Care Bundle)
3. Improving patient experience through better staff engagement
4. Reducing patients' length of stay

2.2.1 Priority 1 - Improving the management of patients with sepsis

2.2.1.1 Description of the priority

Sepsis is the leading cause of death in hospitals worldwide. The incidence of sepsis is increasing, likely in part due to an ageing population who are more at risk of infection.

2.2.1.2 Why did we select this priority?

The UK Sepsis Trust estimates that over 12,300 lives per year could be saved if sepsis is recognised and treated in its early stages. Early identification and treatment is key to reducing the number of deaths from sepsis and there is evidence to show that we can make improvements in our recognition and treatment of sepsis. Administration of intravenous antibiotics within one hour of diagnosis of sepsis is the

gold standard and the priority for treatment as part of the regime known as the 'Sepsis Six'.

2.2.1.3 Did we do what we said we would and what was our performance against this priority in 2017/18?

A plan for delivery of the priority was formulated and an action log created. Funding was provided to support a lead specialist nurse to deliver educational activities and coordinate sepsis awareness across the Trust. The appointment has revitalised the screening tool, with 186 targeted staff trained so far; blood culture training delivered for staff in the Emergency Department and the Medical Assessment Unit; and proposed mandatory training sessions for all nurses and health care assistants.

Innovative practice that has been adopted includes a 'Sepsis Bleep' in the Acute Medical Unit to alert doctors to patients who have been rated red for sepsis; and a proposal for a Patient Group Direction for patients flagged with sepsis, allowing nurse initiated care and first dose antibiotic and fluid delivery by trained nursing staff. All junior medical staff are now required to complete a sepsis online training module as part of their mandatory training.

The relevant Commissioning for Quality and Innovation (CQUIN) data remains variable, with data collected by manually auditing notes for the sepsis-screening tool and the delivery of the Sepsis Six protocol. This auditing has demonstrated that although the correct treatment may have been provided to patients, the correct terminology has not always been used to count towards the CQUIN. The eCARE electronic patient record system, to be implemented in April 2018, will deliver a more accurate auditing process.

We have formed a multidisciplinary sepsis working group, chaired by the Associate Medical Director, and including consultant clinical leads, nursing leads and junior doctors. The Trust is an active member of the Oxford regional sepsis group with learning shared at the sepsis working group.

2.2.2 Priority 2 – Improving our arrangements for reducing stillbirths and early neonatal deaths (Saving Babies' Lives Care Bundle)

2.2.2.1 Description of the priority

The Saving Babies' Lives Care Bundle brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

2.2.2.2 Why did we select this priority?

Although the stillbirth and neonatal mortality rate has fallen by a fifth in England in the last decade, the NHS has recently set out a national ambition to halve the rates

of stillbirths by 2025. The Saving Babies' Lives Care Bundle is designed to reduce stillbirth and early neonatal death.

The care bundle approach is now a recognised and familiar way to bring about improvement in the NHS. Care bundles typically draw together a small number of focused interventions designed to effect improvement in a particular disease area, treatment or aspect of care. When implemented as a package, evidence shows that greater benefits are achieved at a faster pace than if those improvements had been implemented individually.

2.2.2.3 Did we do what we said we would do and what was our performance against this priority in 2017/18?

This Trust has undertaken all four elements of the Saving Babies' Lives care bundle. For our quality priorities we have focused on the care bundle on effective fetal monitoring during labour as this has emerged as a theme when we have looked at some of the care we have delivered.

For high-risk births we regularly check the babies' heart rate using an electronic trace called a CTG (Cardiotocography) which gives an indication of fetal wellbeing. Reading the trace is a complex process so we undertake a second check of every trace to reduce the risk of incorrect interpretation. This is undertaken by the midwife caring for the woman and a second midwife who acts as an independent review. This process is known as 'fresh eyes'.

Labour ward has measured the completion of 'fresh eyes' reviews every hour (from 25 randomly selected sets maternal records) and have reported this on a monthly basis via the nursing metrics system, with the expectation that it will be completed in 90% of cases.

Since implementation of fresh eyes metrics in July 2017, Labour Ward has achieved an average of 86% per month over the past eight months, with scores improving month on month and achieving over 90% for the first quarter of 2018.

2.2.3 Priority 3 – Improving the experience of our patients through better staff engagement

2.2.3.1 Description of the priority

The quality of patient experience, as measured by inpatient satisfaction in acute hospitals, is strongly linked with staff engagement (as it is with other aspects of staff experience). Patient satisfaction is significantly higher in trusts with higher levels of employee engagement, as confirmed through research conducted by Professor Michael West *et al* of Aston Business School.

2.2.3.2 Why did we select this priority?

The staff engagement element of the annual NHS staff survey is derived from elements of engagement across a number of consistent questions, including on the levels of motivation and satisfaction staff feel; and their involvement and willingness to be an advocate of the hospital and its services. The scores across all elements

are converted into an overall staff engagement score for the hospital, which can be benchmarked or compared with other NHS organisations. Having a highly motivated and engaged workforce is vital to staff wellbeing and critical in delivering high quality patient care.

2.2.3.3 Did we do what we said we would do and what was our performance against this priority in 2017/18?

There has been a renewed focus on staff wellbeing and engagement throughout the hospital. A range of new initiatives and interventions were adopted during 2017/18 to support improved engagement, with a view to positively impacting on patient experience. This included the "You Said, We Did" campaign – addressing the areas for improvement from the results of the survey; staff health and wellbeing initiatives, Schwartz rounds; and value based appraisals.

In May 2017, the first "Event in the Tent" was held. This was a landmark event, which will now be held annually, with the aim of increasing staff engagement, participation and feedback. Having just been rated 'good' by the Care Quality Commission, this was also part of the Trust's strategy to build on improvements and progress towards achieving an 'outstanding' rating. The emphasis was on supporting staff to realise this ambition through the development of an open culture in which staff feel confident to challenge poor practice or ineffective ways of working; build confidence in innovation and a shared vision for improvement; as well as a focus on their own health and wellbeing.

Results of the 2017 staff survey revealed that the hospital's overall staff engagement score of 3.80 out of 5 (the higher the better) has remained unchanged since 2015 and is average in comparison to trusts of a similar type. However, the percentage of staff who consider that the trust takes positive action on their health and wellbeing increased from 27.58% in the 2015 staff survey to 41.55% in 2017. In relation to the key finding of 'staff recommendation of the trust as a place to work or receive treatment', the trust's score remained average at 3.74, as it was in 2016; marginally below the national average of 3.75. The key finding for 'staff motivation at work' decreased slightly from 3.95 in 2016 to 3.93 in 2017 but the trust is above the national average of 3.92. With regard to 'staff ability to contribute towards improvements at work', the trust's score remained at 70% in 2017, as it was in 2016 and was in line with the national average of 70%.

Given the importance of the overall staff engagement score to the goal of improving patient experience, the Trust will continue to focus on this area, and for 2018/19 will seek to increase its rating to 3.83.

2.2.4 Priority 4 – We will reduce our patients' length of stay

2.2.4.1 Description of the priority

Ensuring that patients do not stay in hospital for any longer than is clinically necessary improves the quality of care, prevents patients becoming deconditioned and helps to free up acute hospital beds for those patients who need specialist care. All hospitals are facing growing demands on their services and are seeking ways to

improve the experience of patients, promote safe and timely discharge and reduce length of stay.

2.2.4.2 Did we do what we said we would do and what was our performance against this priority in 2017/18?

Nationally there is a drive for hospitals to embed systems and processes that enable patients to be discharged quickly and effectively as soon as they are medically fit to leave hospital. The aim was to reduce the number of 'wasted days' patients spend in hospital (days when they do not need to be in a hospital bed). 'Red and Green Bed Days' is a visual management system introduced in April 2017, and rolled out across MKUH during the course of 2017/18, to help deliver this initiative – which includes the SAFER patient flow bundle. The Red to Green initiative also complimented and supported two other campaigns "End PJ Paralysis" and "Last 1000 Days", which both aim to empower and enable patients and their families to play an important part in patient's discharge planning.

Red to Green is a simple initiative with four central questions that the teams and patient/ carer should be asking and answering on every day of a hospital admission:

1. What is going to happen now, later today and tomorrow to get me sorted out? (The diagnostic tests, therapy interventions etc with specified timelines as to when things ought to happen)
2. What do I need to achieve to get home? (The 'clinical criteria for discharge', which is a combination of 'physiological and 'functional' factors)
3. If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?

The SAFER patient flow bundle is a practical tool to help reduce delays for patients in adult inpatient wards (not maternity). When followed consistently, there are noticeable improvements in patient safety, patient flow and a reduction in length of stay.

The SAFER patient flow bundle stands for:
S: Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
A: All patients will have an Expected Discharge Date and Clinical Criteria for Discharge. This is set presuming ideal recovery and assuming no unnecessary waiting.
F: Flow of patients will commence at the earliest opportunity from assessment units /ED to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.
E: Early discharge. 33% of patients will be discharged from base inpatient wards before midday.
R: Review. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

Into 2018/19 the challenge will be continuing the initiatives and sustaining positive change. Sustainability is achieved 'when new ways of working and improved

outcomes become the norm' (NHS Improving Quality). The control predominantly resides among the professionals delivering services so we as an organisation need to find ways to support, encourage and facilitate clinicians to ensure these initiatives last long term.

2.3 Statement of Assurance from the Board of Directors

During 2017/18 Milton Keynes University Hospital NHS Foundation Trust provided and/or sub-contracted 37 relevant health services.

Milton Keynes University Hospital NHS Foundation Trust has reviewed all data available of care in those 37 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by Milton Keynes University Hospital NHS Foundation Trust for 2017/18.

2.3.1 Clinical Coding Audit

During 2017/18, Milton Keynes University Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit.

2.3.2 Submission of records to the Secondary Users Service

Milton Keynes University Hospital NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:
    - 99.2% for admitted patient care
    - 99.7% for outpatient care, and
    - 98.1% for accident and emergency care
- which included the patient's valid General Medical Practice Code was:
    - 100% for admitted patient care
    - 100% for outpatient care, and
    - 100% for accident and emergency care.

2.3.3 Information Governance Assessment Report

The Milton Keynes University Hospital NHS Foundation Trust's Information Governance Assessment Report overall score for 2017/18 was 76% and was graded Satisfactory.

2.4 Participation in clinical audits

The Trust is committed to undertaking effective clinical audit within all of the clinical services provided. There is recognition that this is a key element in the development and maintenance of high quality patient-centred services.

During 2017/18, The Trust participated in 97% (37 out of 38) of eligible national audits, and 100% (3 out of 3) of national confidential enquiries in which it was eligible to participate in.

2017-18 National clinical audit participation

No	Name of Audit	Did MKUH participate ?	Reason for non-participation	Stage	Number of cases submitted
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes		Action planning	Continuous data collection
2	Adult Cardiac Surgery	N/A	Not applicable	Not applicable	Not applicable
3	BAUS Urology Audits: Cystectomy	N/A	Not applicable	Not applicable	Not applicable
4	BAUS Urology Audits: Female stress urinary incontinence	Yes		Data collection	Not available
5	BAUS Urology Audits: Nephrectomy	Yes		Action planning	Continuous data collection
6	BAUS Urology Audits: Percutaneous nephrolithotomy	Yes		Data collection	Continuous data collection
7	BAUS Urology Audits: Radical prostatectomy	N/A	Not applicable	Not applicable	Not applicable
8	BAUS Urology Audits: Urethroplasty	N/A	Not applicable	Not applicable	Not applicable
9	Bowel Cancer (NBOCAP)	Yes		Awaiting report	Continuous data collection
10	Cardiac Rhythm Management (CRM)	Yes		Action plan monitoring	Not available
11	Case Mix programme (CMP)	Yes		Action plan monitoring	Continuous data collection
12	Congenital Heart Disease (CHD)	N/A	Not applicable	Not applicable	Not applicable
13	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	N/A	Not applicable	Not applicable	Not applicable

14	Diabetes (Paediatric) (NPDA)	Yes		Awaiting report	Continuous data collection
15	Elective Surgery (National PROMs Programme)	Yes		No actions required	Continuous data collection
16	Endocrine and Thyroid National Audit	Yes		No actions required	Continuous data collection
17	Falls and Fragility Fractures Audit programme (FFFAP)	Yes		Action monitoring	Continuous data collection
18	Fractured Neck of Femur	Yes		Action planning	Continuous data collection
19	Head and Neck Cancer Audit (HANA) (TBC)	Yes		Action planning	Continuous data collection
20	Inflammatory Bowel Disease (IBD) programme	Yes		Action planning	Continuous data collection
21	Learning Disability Mortality Review Programme (LeDeR)	Yes		Awaiting report	Continuous data collection
22	Major Trauma Audit	Yes		Action planning	Continuous data collection
23	Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes			Not available
24	National Audit of Anxiety and Depression	No	Not applicable		Not applicable
25	National Audit of Breast Cancer in Older Patients (NABCOP)	Yes		Action national report	Not available
26	National Audit of Dementia	Yes		Action plan monitoring	Not available
27	National Audit of Intermediate Care (NAIC)	No	Not applicable	Not applicable	Not applicable
28	National Audit of Psychosis	No	Not applicable	Not applicable	Not applicable
29	National Audit of Rheumatoid and Early Inflammatory Arthritis	No	Department restructure	Not applicable	Not participated
30	National Audit of Seizures and Epilepsies in Children and Young People	Yes		Data collection commencing	Continuous data collection
31	National Bariatric Surgery Registry (NBSR)	N/A	Not applicable	Not applicable	Not applicable
32	National Cardiac Arrest Audit (NCAA)	No	Trust has run local audit	Data collection	Trust enrolled in national

				commenced 2018	audit Jan 2018
33	National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Yes		Action plan monitoring	Continuous data collection
34	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	N/A	Not applicable	Not applicable	Not applicable
35	National Comparative Audit of Blood Transfusion programme	Yes		Action planning	Not available
36	National Diabetes Audit – Adults	Yes		Awaiting report	Not available
37	National Emergency Laparotomy Audit (NELA)	Yes		Action planning	Continuous data collection
38	National Heart Failure Audit	Yes		Action plan monitoring	Continuous data collection
39	National Joint Registry (NJR)	Yes		Action plan monitoring	Continuous data collection
40	National Lung Cancer Audit (NLCA)	Yes		Action plan monitoring	Continuous data collection
41	National Maternity and Perinatal Audit	Yes		Action plan monitoring	Continuous data collection
42	National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes		Action plan monitoring	Continuous data collection
42	National Ophthalmology Audit	No	IT interface issues	Not applicable	Not applicable
43	National Vascular Registry	N/A	Not applicable	Not applicable	Not applicable
44	Neurosurgical National Audit Programme	N/A	Not applicable	Not applicable	Not applicable
45	Oesophago-gastric Cancer (NAOGC)	Yes		Action planning	Continuous data collection
46	Paediatric Intensive Care (PICANet)	Yes		Action plan monitoring	Continuous data collection
47	Pain in Children	Yes		Action planning	Continuous data collection
48	Prescribing Observatory for	N/A	Not	Not	Not

	Mental Health (POMH-UK)		applicable	applicable	applicable
49	Procedural Sedation in Adults (care in emergency departments)	Yes		Action planning	Continuous data collection
50	Prostate Cancer	Yes		Action plan monitoring	Continuous data collection
51	Sentinel Stroke National Audit programme (SSNAP)	Yes		Action plan monitoring	Continuous data collection
52	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes		Action plan monitoring	Not available
53	UK Parkinson's Audit	Yes		Action plan monitoring	Continuous data collection

During 2017/18 hospitals were eligible to enter data in up to five National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies. The Trust was exempt from participating in two of these. The table below summarises those studies that were applicable to and participated in by the Trust.

National Confidential Enquiry into Patient Outcome and Death Study Eligible 2017/18	**Participated**	**Cases Submitted**
Cancer in Children, Teens and Young Adults	Yes	4
Chronic Neuro disability	Yes	4
Young Peoples mental health	Yes	1
Number of cases submitted were the number requested by NCEPOD		

National audit reports

The Trust has reviewed 18 national audit reports in 2017/18 and the Trust intends to take the actions listed in the tables below to improve the quality of the care and services it provides:

National Chronic Obstructive Pulmonary Disease Audit – Inpatient work stream
Recommendation(s)/Outcomes discussion points and actions we intend to take
1. The clinical lead for Respiratory and COPD is working collaboratively with the CCG to integrate services for patients discharged with COPD and other airways diseases, providing support for community based diagnosis, non- pharmacological

care, optimum pharmacological management and overall leadership.
2. Strengthening IT provision across primary and secondary care to enable seamless access to data at both sites thus improving patient care.
3. Reviewing and augmenting current smoking cessation services across both locations.
4. Considering opportunities to make Spirometry available on ICE for easy access to all.
5. Augmenting staffing levels in Non Invasive Ventilation bays on both male and female respiratory ward improving quality of care.
6. Prioritising complex COPD patients staying beyond 48 hours to the Respiratory Wards.
7. Expanding the respiratory specialist nursing service to provide specialist 24/7 in-reach to admitted COPD and other airway disease patients across respiratory and non-rRespiratory, and especially on the acute medical footprint.
8. Working towards the development of a COPD MDT to work across primary and secondary care, discussing complex and challenging COPD and other Airways disease cases, focusing on patients' individual needs.

National Bowel Cancer Audit
Recommendation(s)/Outcomes discussion points and actions we intend to take
1. Improve care pathways - promote bowel cancer screening and address the significant geographical variation in the uptake of screening. 2. More evidence is required to determine the role of major resection of asymptomatic primary colorectal tumours in the context of synchronous inoperable metastatic disease. Results from the several randomised controlled trials currently underway will be invaluable in this regard. 3. The geographical disparity in the use of adjuvant chemotherapy needs to be explored further – the team will identify where MKUH sits within the disparity. 4. More needs to be done to deliver high quality care with a view to securing further improvements in outcomes. 5. Action is required nationally to reduce risk exposures, support healthy behaviours and mitigate the effects of socioeconomic deprivation in an attempt to reduce regional variation in cancer survival. 6. Priority should be given to actively managing patients with de-functioning stoma following anterior resection and planning early closure whenever possible. 7. Better understanding of the regional difference in the use of pre-operative treatment for rectal cancer patients is required.

National Paediatric Diabetes audit
Recommendation(s)/Outcomes discussion points and actions we intend to take
1. Continue to focus resources on patients with high HbA1c – nurse led high HbA1c clinics. 2. Employ a psychologist as part of the diabetes team to support children and families with diabetes – business case accepted and discussion with Children and Adolescent Mental Health Services (CAMHS) underway to employ additional team member. 3. Work with IT to improve design and function of SPARKLE database so that

activity and data is captured in national audit.
4. Continue to offer pump therapy to families.

National Diabetes in Pregnancy audit
Recommendation(s)/Outcomes discussion points and actions we intend to take
1. Improve preconception care in primary care for women with type 2 – this would improve the number of women taking folic acid preconception, HbA1c levels in first trimester and early referral to the diabetes team

National Prostate Cancer
Recommendation(s)/Outcomes discussion points and actions we intend to take
1. New biopsy methods using template based approaches have been introduced but trans rectal ultrasound (TRUS) biopsy still remains the most commonly utilised nationwide (85% of men). 2. The Trust should start planning for the performance of template biopsies as this will increase theatre resource usage considerably.

National neonatal audit programmer
Recommendation(s)/Outcomes discussion points and actions we intend to take
1. Improve admission temperature by revising guidelines on usage of plastic bags for <34 weeks and education on resuscitation 2. Improve administration of breast milk within 24 hours of admission by allocating dedicated staff and resources- recruitment is in progress 3. Increase the number of babies on breast milk on discharge.

Local audits

The reports of 51 local audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions to improve the quality of the care and services it provides:

Urology Department Quality Improvement activity following participation in national and local audits
1. Set up new urology stone MDT 2. Set up internal urology M&M 3. Review post-op readmissions with sepsis 4. Hold urology away day 5. Review departmental protocols 6. Review Getting It Right First Time review of paediatric surgery pertaining to urology

30 days mortality and 8 days re-admission

1. Continue with biannual audit
2. Continue with current consent process.
3. Continue advising to report and review all post Endoscopy deaths at gastro M+M.

A summary of patient outcomes from patients attending women and men's health physiotherapy including the self-referral continence service

1. In order to complete a more accurate record of discharge results increased compliance with outcome measure recording and completion of the discharge outcomes form is recommended.
2. To highlight with those patients that fail to complete a course of treatment – it should be noted whether at their last review improvement was being made or not.

Assessment of vitamin D deficiency in ward 3 inpatients

1. Check Vitamin D levels in high risk patients.
2. Use guidelines to aid replacement plans.
3. Be careful about over replacement. No need to check replacement although maybe some value if still symptomatic at 3-6months.

Audit of compliance with the standards for melanoma reporting

1. Continue to use proformas for reporting excision specimens of melanomas.
2. Double report all melanomas and difficult melanocytic lesions.
3. Although the Trust does not use proforma for in situ melanomas, it should aim to include the type, both peripheral and deep margins and features of regression if present.

Audit of current Infective endocarditis guidelines against recent published by the European Society of Cardiology (ESC) and Infectious Diseases Society of America (IDSA)

1. Use once daily Gentamicin instead of multiple dosing

2. Delay initiating Rifampicin where indicated

3. Prolong incubation of blood cultures for suspected endocarditis

Audit of Intra-Abdominal sepsis Management

1. Identified that the Trust needs to perform septic screening tool on all patients.
2. Consider an Ambulatory Hyperemesis service to reduce number of overnight stays.
3. Reviewed Trust Hyperemesis Guideline overdue
4. Ensure 1st line antiemetic's are in line with current guidance.

Audit of Orthognathic Surgery Waiting Times

1. Consider re-audit once SMH clinics have been re-established allowing enough time for sufficient sample size to be collected for all units.
2. Extend gold standard to 18 weeks.

Audit of Percutaneous Breast Biopsies

Audit shows 98% accuracy in current practice.

Audit of rejected Imaging requests for Plain film GP requests and CT requests for the 1st quarter of 2016

Audit of sepsis management in Gynaecology patients

1. Improve the availability of Sepsis 6 proformas in Gynaecology admission packs for elective and acute admissions,
2. Increase stock of equipment and sepsis bundles in clinical areas,
3. Increase availability of point of care testing in areas where there are high risk patients.

British Thoracic Society National Paediatric Asthma Audit

1. Improve consistency of the documentation of asthma history
2. Give more consideration to the use of inhaled instead of nebulised treatment
3. Clarify differentiation between viral induced wheeze and LRTI with wheeze
4. Reduce gaps in pre-discharge documentation
5. Improve consistency of advice on GP follow-up

Circumcision in Milton Keynes, an audit of practice over 2 year period

1. Ensure strict adherence to RCS guidelines, BAUS for referral.
2. Use of conservative management.
3. Use of patient information leaflets.

Collection of blood products using BloodTrackSystem

1. Blood track will continue to be monitored daily using inventory check lists produced by the BMS staff and blood track activity list produced by the transfusion practitioner .Any deviations from correct practice will be investigated and shared with blood bank staff and clinical areas.

Compliance to the BAUS Enhanced recovery Programme

1. Increase the use of scanning systems for audit purposes.
2. Create initial approach to laparoscopic appendectomy.
3. Maintain normal appendectomy rate <20%
4. Repeat audit to assess normal appendectomy rate more accurately and to assess the use of laparoscopic approach.

Dietetic Record Card Re-audit

1. Changes are to be made to the documentation of errors and the signing off of entries, so that all errors or additions to entries are initialled and dated.
2. In the future, a refresh of the record keeping standards is to be held every 6 months to ensure the department remains up to date. A re-audit in a year to assess whether the recommended changes have been implemented.

Elective Surgery Outcomes Audit - National Patient Related Outcomes Measures (PROMs) for Elective Inguinal Open Hernia Repair

No actions required - not being audited this year

Febrile neutropenia in children with malignancy

1. Review oncology patients admission pathway
2. Febrile Neutropenia departmental teaching to be held.
3. Paediatric oncology service -trainee induction day to be held, and training to be

provided for staff particularly nursing staff on ward 4 on Central line access

Incisional hernia repair audit

1. Education of all surgeons carrying out incisional hernia repairs
2. Develop local guidelines for the repair of incisional hernias
3. Await development of national guidelines

Induction of labour (QS60)

1. First responders to not wait for speciality team to advise on antibiotics, but to commence without delay.

Initial clerking of patients presenting with abdominal pain

1. Mandatory induction to include proformas for completion
2. Adjusting clerking proformas to include checklist
3. Observations to be added to sepsis proformas and this should be completed at the same time as the clerking proforma.

Major Obstetric Haemorrhage

1. All Obstetric staff should continue to monitor their practice, reflecting on 3rd and 4th degree tears and PPH's to learn.

Milton Keynes Bowel Cancer Audit report

Outcomes of this audit pending data quality review.

MUST Audit using BAPEN's nutritional care tool

1. Aim to MUST screen all patients within 6 hours of admission

2. Fill in MUST tool correctly – training is provided in Essential Skills sessions for nursing staff and HCAs as well as ad hoc training sessions on the wards

3. Take the correct actions based on the MUST score – training as in point 2 above, feedback in person to nurses/HCAs on the ward

4. Offer patients extra food/drink where needed as well as assistance

PICC line service by imaging

1. As there are now an increased number of dedicated slots for PICC placement, another member of staff should be trained to place these lines.
2. The requesting process for the chemotherapy lines should be improved to ensure that only lines that are really needed are requested and that the requests come to Imaging in a timely fashion.

Pilot audit on interobserver and intraobserver of measurement of Breslow thickness using the eyepiece graticule

1. Using the eyepiece graticule for measuring Breslow thickness in melanoma cases is to be used in the borderline categories.
2. There will be minor interobserver and intraobserver variations in measurement which can be reduced by multiple measurements and taking the mean of measurements.

Postnatal Care Pathway

1. Importance of sepsis in gynaecology should attribute the same importance as in any other speciality.

Prescribing burden and paracetamol: can we stop to streamline discharge and save money?

1. CSU to inform patients to ensure B&P are available.

Procedure for confirmation of pregnancy status pre-operatively.docx...

1. Information should be provided in advance for best practice for informed consent.
2. Pre-assessment to consider providing women with written information about risk of anaesthetic and surgery on fetus.
3. Surgical Decision Unit team to review admission documentation to include discussion on the day of admission about pregnancy testing

Quality Improvement Project (QIP) on IV Cannula

1. Consider replacing the current two paged VIP chart with a single paged VIP chart; and include it in the drug chart if possible.
2. Involve nursing staff in the implementation of audit recommendations.
3. Remind each other as medical staff during ward rounds to inspect IV cannulas and other peripheral lines for signs of phlebitis

Re-Audit on quality of consent process in Macmillan Unit

Retrospective audit of the quality of ENT emergency SHO clinic notes

Retrospective Correlation of pre-operative ultrasound results of axilla with final pathology in patients undergoing axillary surgery

Review of the referral pathway for the management of women who test positive for syphilis in the antenatal setting.

Review of the women's health inpatients service

1. There should be an uplift in staffing for the Women's and Men's health team to the extent of one Band 5, within the next 6 months. This is to ensure that the ward can be covered with an appropriate time allowance daily, including those periods of staff leave, training and sickness.

2. It is also proposed that all women who have an episiotomy without assisted delivery and also those with a second degree tear should be offered information from a physiotherapist with regard to wound healing, pelvic floor exercises, bladder care and return to exercise.

Sepsis in Maternity - follow up audit

1. Improve ANTT technique amongst all obstetric and maternity staff
2. Improve hand washing technique amongst all obstetric and maternity staff
3. Improve caesarean section wound care and management
4. Educate women about hand hygiene and wound care
5. Improve the time taken to administer IV antibiotics and complete the sepsis 6
6. Promote the use of the Level 1 Pathway
7. Reduce the caesarean section rate particularly amongst those at higher risk of developing sepsis
8. Further investigate the link between raised BMI, diabetes and risk of developing sepsis

Sickle Cell Proforma Audit

1. Proformas to be made available for use by both the medical and nursing staff
2. Continuous staff education on Sickle Cell Disease

The use of Prothrombin complex concentrate at MKUH are we using it correctly

Treatment of patients refusing blood

1. Information to be disseminated through newsletters, staff meetings, feedback and staff discussions
2. Staff to be made aware that it is everyone's responsibility to hand information over (MDT approach)

Two week wait cancer referral (Paediatric) Audit

Use of Gonad Shielding for Pelvic x-rays (re-audit)

1. Refresher training in the use and correct positioning of gonad shielding to be provided
2. Re-auditing to be carried out in 12 months' time to provide a better overview of possible changes to practice.

Use of Magnesium Sulphate for fetal neuroprotection in Pre-term labour

1. Review of the Trust's pre-term labour, tocolysis and partosure Guidelines to be carried out to ensure that they are consistent with National Guidance.

Use of pain buster in mastectomy and reconstruction – is it worth it?

1. The use of pain busters needs to be explored further to facilitate timely discharge.

2.5 Participation in Clinical Research

This Trust is committed to delivering high quality clinical care. Patients who are cared for in a research-active hospital have better overall healthcare outcomes, lower overall risk-adjusted mortality rates following acute admission and better cancer survival rates. Furthermore, health economic data shows that interventional cancer trials are associated with reduced treatment costs benefitting the NHS

financially. These benefits may result from a culture of quality and innovation associated with research-active institutions. There is a reasonable further assumption that departments and clinicians within the hospital, who are research-active, provide better care. In turn, this suggests that it is desirable to encourage as many clinicians and departments to become research active as is practicable.

The number of patients receiving relevant health services provided by Milton Keynes University Hospital NHS Foundation Trust in 2017/18, recruited to participate in National Institute of Health Research (NIHR) studies approved by a research ethics committee was 2,592 to date, including first patients recruited in two of the commercial studies nationally.

This year 89 studies have contributed to the recruitment figures and we are currently in second position in the Thames Valley Research Network.

The Research and Development department had a budget of £700,000 for 2017/18, which has been used to provide support for portfolio studies across the Trust. This includes research nurses and the support services that are an integral part of the research process namely pathology, pharmacy and radiology. This year the team has continued to grow to support the increasing number of studies taking place across the Trust and we have secured an increase in budget to £715,000 for 2018/19.

Our aim is to provide patients with the latest medical treatments and devices and offer them an additional choice where their treatment is concerned.

2.5.1 Raising the Profile of Research and Development (R&D)

This year we have continued to work towards raising the profile of research and development within the Trust. We have focused on events to tell the people of Milton Keynes, who we work to serve, about the research that is taking place in their local hospital. Our team has held a stand at MK play day to raise awareness of research taking place in paediatrics which was well attended by the local community.

We held stands in outpatients and the education centre for both patients and staff as part of International Clinical Trials Day, May 2017, and supported the ‘Ok to Ask’ campaign, which aimed to increase awareness of trials in the general public and tell them it is ok to ask your clinician about any studies that may be open to you.

A second grant submission has been made for our collaboration with the Open University this time to the Medical Research Council. We have applied for a grant for a clinical trial using fluorescence to detect the spread of cancer during surgery, therefore potentially reducing the number of patients recalled for further surgery. This is one of the collaborations between a researcher from Open University and Mr Chin, general surgeon Consultant, as chief investigator. In this project MKUHFT would act as a sponsor for the clinical trial.

The ‘Canine olfactory detection of urological cancer from human urine’ (MDD) study has continued to receive media attention and the team have delivered some successful healthy volunteer recruitment events in and around Milton Keynes as well as continuing to recruit eligible patients attending MKUHFT.
The team have submitted expressions of interest for several commercial studies during this financial year. We have been awarded commercial studies in cancer, emergency medicine, cardiology, diabetes and stroke. This demonstrates that MKUH

is becoming an organisation recognised by industry, forging relationships with commercial partners wanting to perform quality research within our organisation. This will continue to drive an increase in the quality and quantity of research opportunities offered to our patients and public.

2.6 Goals agreed with Commissioners (CQUIN)

A proportion of Milton Keynes University Hospital NHS Foundation Trust income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between Milton Keynes University Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2017/18 are listed below.

2.6.1 National Goals

2017/18 CQUINs for Milton Keynes University Hospital NHS Foundation Trust			
Indicator	**Indicator Name**	**High level detail**	**Expected delivery 2017/18**
1a	Improvement of health and wellbeing of NHS staff	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, Musculo-skeletal (MSK) and stress	The Trust delivered 50% of this CQUIN
1b	Healthy food for NHS staff, visitors and patients	Building on changes made relating to 2016/17 CQUIN including implementation of healthy food initiatives, including; the banning of price promotions and advertisements on sugary drinks and food high in fat, sugar and salt, ensuring 70% of drinks stocked at sugar free, 60% of confectionary does not exceed 250 kcal and 60% pre-packed meals contain 400 kcal or less	This CQUIN has been achieved in full.
1c	Improving the uptake of flu vaccinations for front line staff	Achieving an uptake of flu vaccinations by frontline clinical staff of 70%.	This CQUIN has been achieved in full. The Trust achieved a

	within Providers		total frontline flu vaccination uptake of 78.07%.
2a	Timely identification for sepsis in emergency departments and acute inpatient settings	Demonstrating percentage of patients who met the criteria for sepsis screening and were screened for sepsis. This indicator applied to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards	The Trust delivered 25% of this CQUIN
2b	Timely treatment of sepsis in emergency departments and acute inpatient settings	Demonstrating the percentage of patients who were found to have sepsis in sample 2s and received IV antibiotics within 1 hour.	The Trust delivered 70% of this CQUIN.
2c	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours	To demonstrating the percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hour with documented outcome of review recorded	This CQUIN has been achieved in full.
2d	Reduction in antibiotic consumption per 1,000 admissions	There are three parts to this indicator: 1. Total antibiotic usage per 1,000 admissions 2. Total usage of carbapenem per 1,000 admissions 3. Total usage of piperacillin-tazobactam per 1,000 admissions	The Trust delivered 66% of this CQUIN.
4	Improving services for people with mental health needs who present to ED	Reduce by 20% the number of attendances to ED for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions and establish improved services to ensure this reduction is sustainable	This CQUIN has been achieved in full.

6.	Offering advice and Guidance (A&G)	To set up and operate advice and guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care.	The Trust delivered 50% of this CQUIN
7.	NHS e-Referrals	Ensuring 100 per cent of consultant led 1st outpatient services are available on the NHS e-Referral Service (e-RS) with adequate slot polling taking place to allow patients to book appointments evidenced by a reduction in 'Appointment Slot Issues' to a rate of 4% or less	The Trust did not deliver this CQUIN.
8.	Supporting Proactive and Safe Discharge	Increasing the proportion of patients admitted via non-elective route discharged to their usual place of residence within 7 days of admission by 2.5 per cent. Timely submissions of Emergency Care Data Set	The Trust delivered 55% of this CQUIN

2.6.2 Specialised Goals

Goal	Goal Name	High level detail	Performance 2017/18
1	Activation system for patients with long term conditions	To develop a system to measure skills, knowledge and confidence needed to self-manage long-term conditions (i.e. HIV) and use that information to support adherence to medication and treatment as well as improving patient outcomes and experience.	This CQUIN has been achieved in full.
2	Clinical Engagement	Improvement of NHS Dental services through engagement with specialty Manager Clinical Network (MCN) to review and improve pathways and outcomes for patients	This CQUIN has been achieved in full.

For 2017/18, the Trust reported achievement of £1.7m (excluding STP engagement payments) representing 64% overall of the value of all CQUINs.

2.7 Care Quality Commission (CQC) registration and compliance

Milton Keynes University Hospital NHS Foundation Trust is required to register with the Care Quality Commission and under its current registration status is registered to provide the following regulated activities:

- Urgent and emergency services
- Medical care
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Milton Keynes University Hospital NHS Foundation Trust has no conditions on its registration. It received no enforcements actions during the reporting period.

2.7.1 Review of Compliance of Essential Standards of Quality and Safety

The Trust underwent an unannounced focused CQC inspection on 12, 13 and 17 July 2016 to check how improvements had been made in urgent and emergency care, end of life care and maternity services.

The other areas of Surgery, Critical Care, Children's Services and Outpatients were not inspected and so their ratings remain from the previous inspection in October 2014. All of these services were rated as "Good" at that time.

2.7.2 Overall Ratings for Milton Keynes University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

2.7.3 Key findings from the report

- All staff were compassionate about providing high quality care
- The emergency department was meeting the four hour target with clear escalation processes to allow for proactive plans to be put into place for patient flow.
- The HSMR (Hospital standardised mortality ratio) was significantly better than the expected rate.
- Improvements had been made in the completion and review of patients DNACPR forms.
- There was a lower rate than the average of neonatal deaths. The Maternity Improvement Board was monitoring this to make further improvements to the service
- Staffing levels were appropriate and met patients' needs at the time of the inspection
- Staff morale was positive and staff spoke highly of the support from their manager
- Local ward leadership was effective and ward leaders were visible and respected.

2.7.4 Areas of Outstanding Practice

- The Medical Care Service had a proactive elderly care team that assessed all patients over 75 years old.
- The Medical Care Service ran a dementia café to provide emotional support to patients living with dementia and their relatives.
- Ward 2 had a dedicated bereavement box that contained soft lighting and furnishings to provide a homely environment for patients requiring end of life care.

2.7.5 Areas of Compliance or enforcements

Milton Keynes University Hospitals NHS Trust received no notifications of compliance or enforcements actions as a result of this report.

Areas for improvement identified by the inspection are below. The action plans for all of these areas have been completed.

- The Emergency Department did not comply with guidance relating to both paediatric and adult mental health facilities
  The Trust has built a dedicated mental health assessment room and now has a purpose built paediatric emergency department with a separate entrance.
- Staff patients and visitors did not appear to observe the hand-washing protocols in the emergency department
  The ED has introduced more regular audit of the hand-washing protocols in the department
- The non-invasive ventilation policy was out of date

Policy now in date

- The Medical Care Service did not have a policy for dealing worth outlying patients
  Policy now in place
- In the Maternity Service examples were shared of inappropriate behaviours and lack of teamwork at consultant level in the service. These behaviours were not observed during the inspection
  Invested in multi-disciplinary leadership and human factors training which includes all of the consultant body. In addition timetables have been rescheduled to allow for team meetings and more multi-disciplinary ward rounds.
- Not all medical staff in maternity has completed the required level of safeguarding children's training
  Compliance now remains over 90%
- There was poor compliance with assessing the risk of venous thromboembolism in the maternity service
  This continues to be a challenge however our new electronic tool for data collection goes live in May 2108

2.8 Data Quality

The Trust recognises the importance of data quality, particularly around the need to have good quality data to support informed decision-making. Consequently, it has invested significant time and resources in developing its management arrangements to improve data quality and some of the notable actions include:

1) The establishment and embedding of the Data Quality Compliance Board (DQCB) to have regulatory focus on ensuring a cultural and behavioural change is instilled in the organisation to improve data quality. This has been supplemented through the on-going monitoring of performance through the data quality dashboard.

2) The development of system assurance statements for key operating systems which provides assurance on the quality of data held on those systems have been completed by Executive Directors. Where it is appropriate and relevant, these statements have recommendations to improve areas of development; the actions to deliver the recommendations are also been monitored and challenge is provided where progress has not been forthcoming.

3) Commencement of an organisation-wide transformational project to ensure administrative duties around outpatient and elective processes is managed in a centralised manner to enable consistent application of national and local policies to support improvement in data quality. The over-arching vision is to get all teams to work together for better and improved data quality.

4) Establishment of an organisational wide training programme to ensure that all staff members are fully conversant with national and local polices. In addition,

this training programme ensures the Trust actively provides context to the importance of accurate data collection and the subsequent use of relevant key data items, thereby promoting understanding across all staff groups.

5) Commitment has also been given by the Executive Management Board to establish a formal training team in the Trust to sustain the improvement in data quality.

All of the above activities have been focused on continuous learning and development in a bid to improve data quality and not settling on the status quo.

In addition, the Trust is actively engaged with its commissioners to monitor the quality of clinical services delivered through the delivery of local and national targets; these include both quality and performance indicators and hence data quality is important to ensure accurate reporting.

The Trust submitted data records during 2017/18 to the Secondary Uses Services (SUS) for inclusion in the Hospital Episode Statistics (HES). It has maintained data completeness over the national average and across the activity areas of admitted care, outpatients and A&E for both NHS number and ethnicity. The table below provides further information on the data completeness for national indicators NHS number and ethnicity*, with national averages.

Data item	Admitted	Outpatients	A&E
Completeness NHS number	99.3 (99.4)	99.7 (99.5)	98.0 (97.1)
Completeness ethnicity	99.4 (96.2)	99.1 (94.2)	94.9 (94.9)

*Figures from the SUS data quality dashboard M9 – national average in brackets was the latest set of information available at the time of writing this report.

2.9 Learning from Deaths

The data for quarters 1 to 4 are illustrated in the graph below outlining the number of deaths within the Trust that have:

1. Been assessed by the consultant responsible for the patient's care with the potential for the case to be 'screened out' of further formal review. This active assessment process recognises that in many cases death in hospital will have been inevitable and appropriate. The process assists in directing collective review efforts to those cases where multi-professional review is likely to lead to learning. A subset of those cases 'screened out' is subjected to formal review at random.

2. Undergone formal review – the Trust aims for ~ 25% of all deaths to undergo a formal review process. It should be recognised that deaths that occur within Q4 are still undergoing the process of formal review in accordance with the Trust's mortality policy.

3. Judged as potentially 'avoidable' – using the current system of classification within the Trust this includes 'suboptimal care where different management

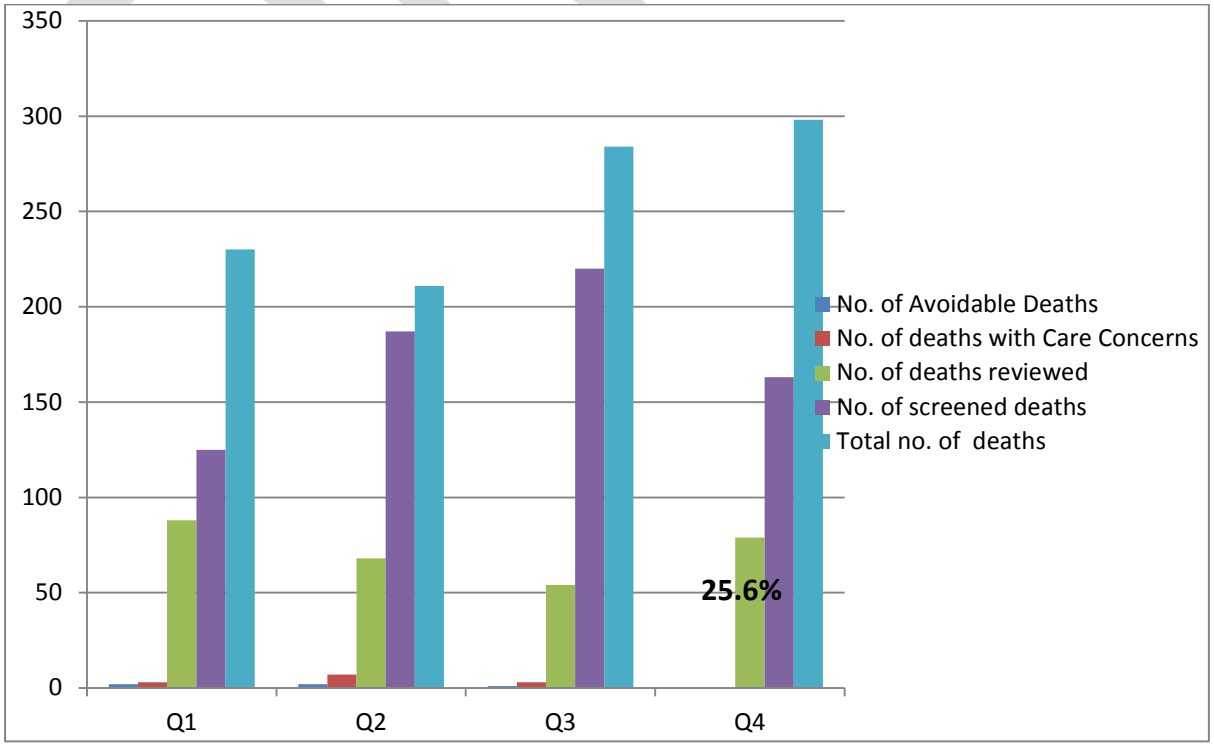
MIGHT have changed outcome and 'suboptimal care where different management WOULD have changed outcome'

4. Judged as 'non-avoidable' but where care quality concerns have been identified. This includes 'suboptimal care where different management WOULD NOT have changed outcome'.

As the Trust adopts the Royal College of Physicians methodology of Structured Judgement Reviews the classification of deaths and 'avoidability' will change.

	Q1	Q2	Q3	Q4
No. of deaths	230	211	284	298
No. of deaths assessed by responsible consultant (% of total)	54%	89%	77%	55*
No. of reviews (% of total)	88 (38.2%)	63 (29.9%)	54 (19%)	79 (26.5%)*
No. of deaths with Care Quality concerns (%)	3 (1.3%)	7 (3.3%)	3 (1.1%)	0*
No. of potentially avoidable deaths (%)	2 (0.8%)	2 (0.5%)	1 (0.5%)	0*

* Q4 data are provisional and are still subject to further modification (as formal review processes occur within the Trust's clinical divisions).



2.9.1 Qualitative information of deaths (27.4, 27.5 and 27.6)

Q1 Avoidable deaths (2)

1. A woman in her 8th decade died in the Department of Critical Care. Following a Serious Incident investigation it was concluded that there were delays in chasing the results of investigations which may have contributed to the death of the patient. Knowledge of the results in an appropriate timeframe may have allowed surgical treatment to remove the source of sepsis.
   Actions and assessment of impact (*in italics*)
   a. Changes to Standard Operating Procedures to clarify members' roles – *problems that arise in chasing of investigations associated with Serious Incidents are reviewed in the Trust Serious Incident Review Group (SIRG).*
   b. Additional afternoon clinical handover for on call staff – *in place*.

2. A woman in her 8th decade died of a potentially treatable surgical problem. A Serious Incident review identified failures in escalation of care in a patient with deteriorating vital signs and blood results as per Trust policy, uncompleted Trust Sepsis documentation and insufficient senior clinical review. It was considered that these elements of suboptimal care may have contributed significantly to the woman's death.
   Actions and assessment of impact (*in italics*)
   a. Education to embed Sepsis 6 guidance within surgical team – *newly appointed Trust Sepsis Nurse whose role includes education and reviewing adherence to Sepsis 6 guidance.*
   b. Surgical team to develop working practice in line with National 7 Day Standards (7DS) guidance including consultant review of emergency patients – *Trust currently reviewing adherence to 7DS guidance and engaging in national 7DS audits*.
   c. Additional training for nursing staff completing NEWS observations charts – *ongoing action*.
   d. Teams to adopt SBAR communication tool to support escalation of deteriorating patients - *problems that arise in use of SBAR tools associated with Serious Incidents are reviewed in SIRG.*

Q2 Avoidable deaths (1)

A surgical patient in her 8th decade with multiple co-morbidities died in the Department of Critical Care. Initial review of the case found that the patient was not clinically reviewed by medical staff appropriately and an ultrasound scan report showing evidence of pathology was not chased up by medical staff in a timely manner.

Actions from SIRG and assessment of impact (*in italics*);
   a. Instil culture of screening for sepsis – *ongoing review by Sepsis working group*.
   b. Strengthen online medical handover tool – *to review following eCARE implementation*.

c. Friday afternoon handover to on–call team re-instigated – *in place*.
d. Update Standard Operating Procedure for duties of On-Call doctor to clarify team roles.

Q3 Avoidable deaths (1)

A surgical patient in his 10th decade had relatively minor emergency surgery. Intravenous fluids were prescribed at a rate too great for a frail elderly patient with chronic heart failure. This likely contributed to a degree of fluid overload and pulmonary oedema. Prior clerking of the patient including poor documentation of patients' medicines.

Actions and assessment of impact (*in italics*)

a. Surgical Division to disseminate learning points regarding fluid prescription and the importance of medication reconciliation at clerking to junior doctors and medical students – *FY1 training session undertaken, fluid balance to be included in surgical simulation training and awaiting completion of audit of fluid prescriptions.*

2.9.2 Indicators 27.2, 27.8 and 27.9

These indicators will become relevant in the 2018/2019 report when historical data will then be available.

2.9.3 SHMI (Core indicators 12)

The latest SHMI published by HSCIC for the rolling 12 months to June 2017 = 0.995 '**as expected'** banding range.

2.9.4 Palliative Care (Core indicators 13)

The palliative care coding rate was 5.49% against a national rate of 4.05%.

2.10 Reporting against core indicators

Set out in the table below are the quality indicators that Trusts are required to report in their Quality Accounts.

Additionally, where the necessary data is made available to the Trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) is included for each of those listed in the table with

a) The national average for the same; and

b) With those NHS Trusts and NHS Foundation Trusts with the highest and lowest of the same, for the reporting period.

Where data is not included this indicates that the latest data is not yet available from the NHS Information Centre.

2.10.1 Indicator 1: Summary Hospital-Level Mortality Indicator (SHMI) value and banding

Domain 1: Preventing People from dying prematurely						
12. Domain of Quality	Level	2013/14	2014/15	2015/16	2016/17	2017/18
Summary Hospital-level Mortality Indicator (SHMI)	MKUHFT	1.04 (Band 2)	0.95 (Band 2)	1.04 (Band 2)	1.04 (Band 2)	0.99 (Band 2)
	National	1.0	1.0	1.0	1.0	1.0
	Other Trusts Low/High	*It is not appropriate to rank trusts by SHMI*				

Milton Keynes University Hospital NHS considers that this data is as described for the following reasons: The data sets are nationally mandated, and internal data validation processes are in place prior to submission.

There is an increasing level of scrutiny of mortality information across services provided by the Trust an in depth analysis where mortality levels are outside the normal range. We are also now reviewing a percentage of all deaths that occur within the hospital, as described on page 35 of this report.

2.10.2 Indicator 4 – 7: PROM scores for groin hernia surgery, varicose veins surgery, hip replacement surgery, knee replacement surgery

Domain 3: Helping people to recover from episodes of ill health or following injury						
18. Domain of Quality	Level	2013/14	2014/15	2015/16	2016/17	2017/18
(i) Groin hernia surgery	MKUHFT		82.30%	88.80%	insufficient data	28.57%*
	National		87.70%	87.80%	88%	
	Other Trusts Low/High					
(ii) Varicose vein surgery	MKUHFT		insufficient data	insufficient data	insufficient data	35.41%*
	National		84.10%	83.70%	84.20%	
	Other Trusts Low/High					
(iii) Hip replacement surgery	MKUHFT		78.00%	83.10%	insufficient data	97.42%
	National		79.70%	80.00%	81.10%	
	Other Trusts Low/High					
(iv) Knee replacement surgery	MKUHFT		81.00%	74.60%	75.50%	115.33%**
	National		73.70%	74.30%	insufficient data	
	Other Trusts Low/High					

The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This assists the NHS in measuring and improving its quality of care.

Milton Keynes University Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services: seeking to improve the response rates of post-operative questionnaires and reviewing the data once it becomes available. It should be noted that collection of data relating to varicose vein surgery and groin hernia surgery stopped in October 2017 following cessation of the

requirement to collect this information. It should also be noted, in relation to knee replacement surgery that during some months of the year, the participation rate for PROMs exceeded 100%, reflecting an increase in activity above what had been recorded in Hospital Episode Statistics (HES). This would either have been as a result of an increase in referrals or bringing activity formerly attributed to independent hospitals back in-house.

The patient outcome measures scores are as follows:

Organisation	Procedure	Health gain	Improved	Unchanged	Worsened
England	Groin hernia surgery	0.086	51.3%	31.1%	17.7%
MKUH		0.107	45.9%	35.1%	18.9%
England	Varicose vein surgery	0.092	51.9%	31.2%	16.9%
MKUH		0.043	50%	33.3%	16.7%
England	Hip replacement surgery	0.437	89.1%	5.5%	5.4%
MKUH		0.433	86.1%	5.6%	8.3%
England	Knee replacement surgery	6.850	81.1%	9.8%	9.1%
MKUH		8.100	82.9%	9.5%	7.6%

2.10.3 Indicator 8: Emergency Readmissions to hospital within 28 days

Domain 3: Helping people to recover from episodes of ill health or following injury						
19. Domain of Quality	**Level**	***2013/14**	***2014/15**	***2015/16**	****2016/17**	****2017/18**
Patients readmitted to a hospital within 28 days of being discharged	**MKUHFT**	12.20%	11.14%	11.47%	11.14%	
	National	11.61%	12.00%	12.20%	12.33%	
	Other Trusts Low/High	*7.87%/16.95%*	*7.94%/15.98%*	8.52%/16.44%	*8.45%/16.19%*	

*Data sourced from Dr Foster (full fiscal year)
**Data sourced from Dr Foster (fiscal year to January 2017)

2.10.4 Indicator 9: Responsiveness to inpatient personal needs

Domain 4: Ensuring that people have a positive experience of care						
20. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Responsiveness to the personal needs of patients	**MKUHFT**	65.3%	65.4%		64.6%	Next update: Aug-18
	National	68.7%	68.9%	69.6%	68.1%	
	Other Trusts Low/High	54.4%/84.2%	59.1/86.1%	58.9%/86.2%	60%/85.2%	

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.

The Trust's patient experience team continues to work with the clinical teams to with a view to improving patients' experience of receiving care. During 2017/18, work started on the drafting of a new patient experience strategy which will be adopted and implemented in 2018/19.

2.10.5 Indicator 10: % of staff who would recommend the provider to friends or family needing care

Domain 4: Ensuring that people have a positive experience of care						
20. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Staff who would recommend the trust to their family or friends	**MKUHFT**	59%	61%	64%	69%	
	National	66%	59%	69%	65%	
	Other Trusts Low/High	40/94%	35/84%	46/89%	48%/91%	
Patients who would recommend the trust to their family or friends (Inpatient FFT - February in each year available)	**MKUHFT**	*Not a comparable methodology (FFT Score)*	96%	95%	96%	
	National		95%	96%	96%	
	Other Trusts Low/High		82%/100%	74%/100%	76%/100%	

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.

In 2017/18, 67% of MKUH staff indicated that they would recommend the Trust to their friends or family as a place to receive care. This is against a national average of 61% based on the 2017 national staff survey. The Trust has taken action to further improve this rate and the quality of its services by continuing to ensure that staff feel supported and that any concerns that they have are heard and responded to. Staff are able to provide feedback through a number of different methods, including by email to the Chief Executive via “Ask Joe” inbox. Weekly messages from the Chief Executive include details of compliments from patients and relatives to individual members of staff and teams. The Event in the Tent which was held for the first time in May 2017 has been hugely successful in

2.10.6 Indicator 11: % of admitted patients risk assessed for VTE

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.

The Trust is taking action to improve this rate, and the quality of its services. It is continuing to review and build upon the robustness of its processes in this area. Actions are in place to bring about significant improvement to its performance as set out below.

2.10.7 Indicator 12: Rate of Clostridium difficile (C .diff)

Antimicrobial resistance continues to play an important role in driving the current numbers of *Clostridium difficile* and the emergence of new types.

Clostridium difficile although greatly reduced in terms of the numbers of cases seen at the MKUH, should still be recognised as a major cause of healthcare antibiotic-associated diarrhoea.

Antimicrobials used for treating every kind of infection may potentially promote *C. difficile* infection (CDI). After antibiotic therapy, the protective intestinal microbiota is disrupted allowing ingested or resident *C. difficile* to colonise the gastrointestinal tract and infect the host. Antibiotic resistance enables *C. difficile* to grow in the presence of drugs, so strains resistant to multiple agents may have a selective advantage.

The MKUH CDI multidisciplinary team closely monitor therapy in support of tempering the inflammatory response preventing severe infection and resultant poor outcome.

Primary risk factors for the development of CDI include advanced age (greater than 65 years), antimicrobial use, severe illness, and hospitalisation. Secondary factors that also increase the risk include gastric acid suppression (with proton pump inhibitors or histamine-2 receptor antagonists), gastrointestinal procedures, chemotherapy, residence at a long-term care facility, inflammatory bowel disease, and immunosuppression. Furthermore, in those infected with C. difficile, low levels of vitamin D are now suspected to be an independent predictor of poor outcome and are associated with higher recurrence.

The Department of Health threshold is 39 cases; our internal is set at 22.

As of 12 March 2018, 13 cases of CDI have been reported as attributed to the MKUH, which equates to 8.91 per 100,000 bed days. Patients reported have an age range of 78 to 92 years, 10 female, three male – the majority of cases are within medicine, all have chronic co-morbidities. The definition of hospital associated CDI is those patients that test positive at 72 hours following admission.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm						
23. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Patients admitted to hospital who were risk assessed for venous thromboembolism (Q3 results for each year)	**MKUHFT**	96.0%	96.0%	95.1%	85.6%	76.9%
	National	96.0%	96.1%	95.6%	95.8%	95.4%
	Other Trusts Low/High	80%/100%	90%/100%	79%/100%	80%/100%	76%/100%
24. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Rate of C.difficile infection (per 100,000 bed days)	**MKUHFT**	22.5	23.4	10.3	6.1	Next update: Aug-18
	National	14.7	15.0	14.9	13.2	
	Other Trusts Low/High	0/37.1	0/62.6	0/67.2	0/82.7	
25. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Rate of patient safety incidents per 100 admissions (and the rate that resulted in severe harm or death)	**MKUHFT**	5.1 (0.01)	27.5 (0.06)	28.4 (0.01)	30.7 (0.07)	Next update: May-18
	National (Acute)	8.7 (0.07)	37.1 (0.19)			
	Other Trusts Low/High	1.2 (0)/15.5 (0.37)	3.6 (0.02)/82.2 (1.53)			

2.10.8 Indicator 13: Rate of patient safety incidents and % resulting in severe harm or death

The Trust reported 5123 Patient Safety Incidents between 1 April 2017 and 31 March 2018.

Of these, 9 were reported as causing severe harm or death, equating to 0.2% of the total Patient Safety Incidents for the period. It should be noted, however, that some incidents are reported retrospectively, as a result of which the total figure could rise.

Furthermore, as investigations proceed, the severity of harm of some incidents could change.

The Trust reports patient safety incidents onto the National Reporting & Learning System (NRLS). NHS England uses the data to monitor incident trends NHS-wide and they produce a bi-annual report comparing the Trust to other acute organisations. The reporting rate of all incidents has increased, but the Trust continues to be one of the lowest reporting organisations. NRLS latest available data (September 2017) reports the percentage of incidents reported by the Trust as either none or low harm make up 99% of the incidents reported compared to 98.9% reported on average by acute organisations, and the percentage of incidents reported as moderate at 1% less than that of the average, and the percentage of severe or death incidents 0.1% lower than the average. Actions have been put in place to increase awareness of the importance of reporting incidents and to encourage the report of incidents including event in the tent focusing on patient safety, revised mandatory and refresher training and an incident awareness campaign.

Part 3: Other Information

3.1 Review of Quality of Care 2017/2018

3.1.1 Patient Safety

3.1.1.1 Hand Hygiene

The transfer of organisms between humans can occur directly via hands, or indirectly via an environmental source (e.g. clinical equipment, toys or sinks) (Loveday et al, 2014). It is universally acknowledged that the hands are the principal route by which cross-infection occurs and that hand hygiene is the single most important factor in the control of infection (Weston, 2013).

The Trust's hand hygiene compliance rate for 2017/18 is 86%, and it is committed to increasing and maintaining hand hygiene compliance by actively promoting education programmes on hand hygiene and "bare below the elbow". Hand hygiene compliance is audited trust wide on a monthly basis and reported to the infection and prevention and control quarterly meetings.

The occasions when hand hygiene should be performed have been summarised into the '5 Moments for Hand Hygiene' document, as these are considered the most fundamental times for hand hygiene to be undertaken during care delivery and daily routines (National Patient Safety Agency, 2009).

3.1.1.2 Hospital Acquired Pressure Ulcers (grade3&4)

Hospital-acquired pressure ulcers are serious clinical complications that can lead to increased length of stay, pain, infection, and, potentially death.

All pressure ulcers are reported and a pressure ulcer summit is undertaken where all parties involved in the patient's care are invited to review the care with the senior nurse for the area to complete a comprehensive timeline to identify causes, themes

and learning. This information is used to inform the decision of category of pressure ulcer and whether it was unavoidable or avoidable and therefore hospital acquired. All grade 3 and 4 pressure ulcers are reported as serious incidents and a 72 hour report is produced using the collation of information from the summits

Grade 3 and 4 pressure ulcers are reported as a potential safeguarding concern regardless of the decision about whether it was avoidable. All such pressure ulcers are monitored monthly through the Trust's Nursing and Midwifery Board and quarterly through the Safeguarding Committee. The prevention of pressure ulcers has been a quality priority for 2017/18 and will continue to be a key indicator of quality and ongoing improvement for 2018/19. In 2017/18, the Trust recorded 16 Grade 3 pressures ulcers, of which 6 were avoidable. There were 2 unavoidable Grade 4 ulcers.

3.1.1.3 Patient Falls

The risk of falling is multicomponent and the more risks a person has, the greater their risk of falling. The strongest risk factors for a fall are age and a previous fall. Falls can cause patients distress, pain, injury, prolonged hospitalisation, and death. Falls also result in loss of confidence and independence, particularly where family members, carers and health professionals' reactions are to be overly protective. Falls in hospitals therefore impact on quality of life, health and healthcare costs and present significant clinical, legal and regulatory problems.

The National Institute for Health and Clinical Excellence (NICE) has recommended that falls assessments for patients at risk of falling and should be considered. This should be performed by a healthcare professional with appropriate skills and experience. At MKUH all assessments are completed by registered nurses and measured within the Adult Nursing Metrics collected for each ward monthly and monitored through Nursing and Midwifery Board.

Frailty is a complex clinical condition associated with adverse health outcomes, including increased risk of falling. Identifying frailty is essential to ensure that the disproportionate change in health state that characterises frailty is considered when deciding on the targeted interventions. The Trust has embraced and launched national campaigns to support the prevention of deconditioning for patients whilst in hospital including "End PJ paralysis" and "Last 1000 days".

Education and training of staff is necessary to help ensure compliance is maintained long term and this is delivered through the essential skills training programme delivered by the Practice Development Team. The Trust recorded 13 falls with moderate harm for 2017/18, a reduction of 4 from previous year.

3.1.1.4 Duty of Candour

The Trust looks to proactively be open and honest in line with the Duty of Candour requirements and looks to advise/include patients and/or next of kin in investigations. From March 2017 a covering letter was included in the Trust bereavement packs informing that all deaths across the organisation are investigated and if relatives had concerns regarding care or treatment we would look to include this in the Trust mortality reviews and feedback the findings.

In addition for all serious incidents the Head of Risk and Clinical Governance writes formally advising that a root cause analysis (RCA) investigation is being undertaken and inviting patients/next of kin to be involved if they wished. This is subsequently followed up on completion of the RCA with a copy of the report and the opportunity to meet the investigation leads to discuss the findings.

This process has received positive feedback and helped to give reassurances that as an organisation we look to actively learn from incidents and put in place mitigation against other similar incidents in the future.

3.1.1.5 Never events

There were four never events during this timeframe.

NHS England Never Event 2 – Wrong implant/prosthesis:

During the submission of data to the National Joint Registry (NJR) it was noted that there was a mismatch of implants used on a trauma patient who had undergone a hybrid (uncemented cup with a cemented stem) total hip replacement (THR). The cemented femoral component made by Stryker was used with a femoral head component made by Biomet. These two components should not be matched for this procedure because of their taper difference.

Following this incident the World Health Organisation (WHO) surgical checklist has been revised to include an implant 'pause' as a component check (before insertion) and a further check at the Sign Out before the surgeon starts closure. The standard operating procedure (SOP) implant has also been revised with the inclusion of specific wording for other speciality implants, and formal documentation on prosthesis/implant request from the initial trauma meeting. Signage to remind staff of component/implant compatibility is now displayed in theatres and two experienced members of the theatre team are required to check components and Surgeon to sign and formally approved the prosthesis compatibility in theatres before he gets scrubbed.

NHS England Never Event 3 – Retained foreign object post procedure:

The patient was admitted for tension free vaginal tape (TVT) cystoscopy and posterior repair and one day postoperatively a gauze swab was found protruding from her vagina, which had not intentionally been left insitu and should have been identified as part of the swab count in theatre.

Following the incident appendix 11 in the Theatre Operational Policy (swab, needle, sharp, instrument count) to include that there must be a swab count before wound closure/completion of an operative procedure and another count when ALL procedures are completed (e.g. invasive/non-invasive after wound closure like catheterisation).

NHS England Never Event 1 - Wrong site surgery:

A patient was admitted electively for a computerised tomography (CT) guided biopsy of the right lung mass. Post biopsy the patient developed a pneumothorax (which is

a recognised complication of the procedure). The patient was then repositioned from the prone (lying face downwards) position he had been in for the biopsy to a supine (lying face upwards) position. This led to a chest drain being inserted into the left lung.

Following the incident the SOP for interventional radiology has been revised to include that Operators should not change mid procedure and the person who prepares and anaesthetises the area should be the person who performs the procedure, and patients are now marked with the side of abnormality on the anterior and posterior of the chest, thus should the positioning change in an emergency situation the radiology nurses and other staff will have a clear opportunity to highlight a potential mistake. Staff also attended a simulation training session replicating such a scenario.

NHS England Never Event 5 - Administration of medication by the wrong route:

A patient was given oral solution Methadone in a syringe driver instead of the injectable solution.

This remains under investigation currently. No harm came to the patient as a consequence of the error.

3.1.16 Learning

The Trust takes learning from serious incidents, incidents, claims and complaints very seriously to ensure patient safety, patient experience and to help mitigate future occurrences. The Trust's Serious Incident Review Group (SIRG), chaired by the Medical Director/Associate Medical Director robustly review all RCA investigations, action plans and any incidents reported with a moderate grading or above to ensure that appropriate investigation and learning is in place. This is cascaded for divisional learning through the Clinical Governance Facilitators and a variety of newsletters or other communication mediums. All serious incident investigations are only closed on receipt of the evidence to support the completion and embedding of the action plan, and deep dives are commissioned if/where there are any trends in incident reporting that would point to a failure to learn from incidents.

The Trust held a 'pop up event in the tent' on the 23rd October 2017 with presentations on the Trust never events and an 'open space on reporting and learning from incidents - making MKUH safer, and the September plenary session was on incident reporting and the importance of learning from incidents.

Failure to learn from incidents and complaints is included in the Board Assurance Framework (BAF) and Divisional risk registers, with assurances provided at the Quality and Clinical Risk Committee.

3.1.2 Clinical Effectiveness

CLINICAL EFFECTIVENESS						
Indicator	**Measurement used**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**

Hospital standardised mortality ratio (HSMR)	Risk of death relative to national average case mix adjusted from national data via Dr Foster Intelligence: this is a national definition. Target is below 100	88.1	90.0	82.9	89.5	89.7
Perinatal death rate (per 1,000)	This data is provided to the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries)	7.8	4.8	3.9	4.2	5.8
Still birth rate	Per 1,000 deliveries	5.7	2.1	3.2	3.4	4.0
Readmissions within 30 days	Emergency admissions within 30 days of elective discharge, including day cases. Internally set target	8.1%	7.3%	6.8%	7.2%	8.2%

3.1.3 Patient Experience

PATIENT EXPERIENCE				
Indicator	**Measurement used**	**2015-16**	**2016-17**	**2017-18**
Complaints	**The number of complaints from patients received by the Trust**	**902**	**838**	**1256**
Midwife : birth ratio	Birth Rate Plus Midwifery Workforce planning tool	1 to 32	1 to 31	1 to 29
Friends and Family Test (Patient Recommend Rate)	Percentage of patients that said they were likely or very likely to recommend NHS services at the Trust		90%	94%

In 2017/18 the Trust undertook the national patient surveys within Emergency Department; Adult Inpatient; Children & Young people Inpatients and Maternity. Results from these surveys and other insight gained from patients, families and carers are collated, analysed and shared with colleagues to create action plans for change and improvement.

The Trust receives approximately 1,800 Friends and Family Test (FFT) responses a month, from over 65 clinical areas including wards and out-patient clinics. The averages recommend rate for the Trust is 94%. The FFT feedback is collected electronically in many areas and by SMS text messaging in Emergency Department (ED). The electronic and web based responses are in addition to the 'paper survey'. FFT feedback forms are available for children, as an 'Easy Read' format, large print and additionally can be printed on yellow paper for example for patients in our eye clinic.

FFT responses and feedback received via social media (e.g. Facebook, Twitter, NHS Choices and Care Opinion) are being shared as quickly as possible to the

relevant wards and departments. This prompt feedback can mean that appropriate actions can immediately in response to concerns raised. There is also a programme of feedback directly using our stakeholders which include staff and members of the public, these include 'Walk the Patch' and '15 Step Challenge' visits to wards and departments, where feedback is shared promptly to facilitate change and improvement in patient experience. The Patient Experience & Engagement Manager in partnership with the Complaints / PALS team produce a quarterly report for divisions and management board detailing information collated from patient feedback including complaints and compliments. As a Patient Experience Team we collate all feedback into a ward specific 'improvement meeting' where we analyse and discuss feedback data and information with senior ward staff and create localised improvement plans which are monitored and managed by the Divisions.

3.2 Performance against key national priorities

Performance against key national priorities and regulatory requirements 2014 to 2018					
Indicator	**Target and source (internal /regulatory /other)**	**2014-15**	**2015-16**	**2016-17**	**2017-18**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96% (National)	98%	99%	99%	
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	85% (National)	87%	84%	86%	
Maximum wait of 2 weeks from GP referral to date first seen for all cancers	93% (National)	95%	95%	95%	
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments	98% (National)	100%	100%	100%	
Maximum waiting time of 31 days for subsequent cancer treatments: surgery	94% (National)	100%	98%	98%	
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients	93% (National)	96%	95%	94%	
Referral to treatment in 18 weeks - patients on incomplete pathways	92% (National)	93%	86%	93%	91%
Diagnostic wait under 6 weeks	99% (National)	99%	98%	100%	99%
A&E treatment within 4 hours (including Urgent Care Service)	95%	92%	94%	92%	91%
Rapid Access Chest Pain Clinic % seen within 2 weeks					
Cancelled operations: percentage readmitted within 28 days	95% (National)	99%	86%	87%	67%
Clostridium difficile infections in the Trust	39 (National)	35	20	10	13
MRSA bacteraemia (in Trust)	0 (National)	0	2	2	3
MRSA bacteraemia (across Milton Keynes total health economy)		3			

ANNEX 1 – Statement from NHS: Milton Keynes

Statement Milton Keynes Healthwatch

Statement from Milton Keynes Council Quality Account's Panel

Statement from Central Bedfordshire Council Health Overview and Scrutiny Committee

ANNEX 2 –Statement of Directors' Responsibilities in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to May 2018
    - Papers relating to quality reported to the Board over the period April 2017 to May 2018
    - Feedback from the commissioners dated xx May 2018
    - Feedback from governors dated 22 May 2018
    - Feedback from the local Healthwatch organisation dated xx May 2018
    - Feedback from Local Authority dated xx May 2018
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, being reported to Trust Board in July 2018.
    - The national patient survey received in April 2018
    - The national staff survey received in March 2018
    - The Head of Internal audit's annual opinion over the Trust's control environment dated xx May 2018
- The Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

.....Date.....Chairman

.....Date.....Chief Executive

Annex 3: Independent Auditor's report

Glossary

A & E	**A & E**	**Accident & Emergency**	**hospital department specialising in the acute care of patients who arrive without a prior appointment**
AHP	**AHP**	**Allied Healthcare Professional**	**Generic term for professionals other than doctors and nurses who treat patients, therapists, physios, dieticians etc**
ALOS	**ALOS**	**Average Length of Stay**	**the average amount of time patients stay in hospital**
Amber		**Amber**	**Projects will be assessed as having an overall risk rating of amber where it is considered that the project is not delivering to plan in respect of progress and/or impact, however, appropriate action is planned and/or is underway.**
AO	**AO**	**Accountable Officer**	**A person responsible to report or explain their performance in a given area.**
APR	**APR**	**Annual Plan Return**	**Submission of the annual plan to the regulator**
BAF	**BAF**	**Board Assurance Framework**	**Board document to assure the Board that risks to strategic priorities are being managed**
BoD	**BoD**	**Board of Directors**	**Executive Directors and Non Executive Directors who have collective responsibility for leading and directing the foundation trust**
Caldicott Guardian		**Caldicott Guardian**	**Chief clinician who is held responsible for clinical record keeping (from Caldicott enquiry outcomes)**
CAMHS	**CAMHS**	**Children and Adolescent Mental Health Services**	**Specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties**
CBA	**CBA**	**Cost Benefit Analysis**	**A process for calculating and comparing the costs and benefits of a project.**
CCG	**CCG**	**Clinical Commissioning Group**	**Replaced Primary Care Trust. Led by local GPs to commission services**

CDiff	**Cdiff**	**Clostridium difficile**	**A bacterial infection that most commonly affects people staying in hospital**
CDU	**CDU**	**Clinical Decisions Unit**	
CE/CEO	**CE/CEO**	**Chief Executive Officer**	**Leads the day to day management of the Foundation Trust**
CF	**CF**	**Cash Flow**	**The money moving in and out of an organization**
CGF	**CGF**	**Clinical Governance Facilitator**	**Co-ordinates senior leadership team (doctor, nurse and manager) in new CSUs (replace HCFs.**
CIP	**CIP**	**Cost Improvement Programme**	**Also known as Transformation programme**
CoA	**CoA**	**Chart of Accounts**	**A list defining the classes of items against which money can be spent or received.**
Code Victor		**Code Victor**	**Major Emergency Alert**
CoG	**CoG**	**Council of Governors**	**The governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public**
Common Front Door		**Common Front Door**	**Area where urgent care and A & E services can be co located**
CoP	**CoP**	**Code of Practice**	**A set of regulations**
CPD	**CPD**	**Continuing Professional Development**	**Continued learning to help professionals maintain their skills and knowledge**
CQC	**CQC**	**Care Quality Commission**	**Regulator for clinical excellence**
CQUIN	**CQUIN**	**Clinical Quality Incentive Scheme**	**The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation.**
CSU	**CSU**	**Clinical Service Units**	**Business units in MK Hospital**
CTG	**CTG**	**Cardiotocography**	**a technical means of recording the fetus fetal pulse heartbeat**

Datix		**Datix**	**Risk management system**
DD	**DD**	**Due Diligence**	**Is the term used to describe the performance of an investigation of a business or person**
DGH	**DGH**	**District general hospital**	
DH/DoH	**DH/DoH**	**Department of Health**	**The ministerial department which leads, shapes and funds health and care in England**
DIPC	**DIPC**	**Director of Infection Prevention Control**	
DNA	**DNA**	**Did not Attend**	**A patient who missed an appointment**
DOC	**DOC**	**Doctor on call**	
DOCC	**DOCC**	**Department of Critical Care**	
DoF	**DoF**	**Director of Finance**	**The Board member leading on finance issues in the trust; an executive director**
DOSA	**DOSA**	**Day of Surgery Admission**	**When patients are admitted on the day of their surgery rather than the day before**
DPA	**DPA**	**Data Protection Act**	**The law controlling how personal information is used**
DTOCs		**Delayed Transfer of Care**	**Patients who are medically fit but have not been discharged**
Dr Foster		**Dr Foster**	**Benchmarking tool to assess relative performance**
Duty of Candour		**Duty of Candour**	**Consultation on including a contractual requirement for health providers to report and respond to incidents, apologise for errors etc**
ED	**ED**	**Executive Directors' (meeting)**	**Semi-formal meeting of Executive Directors on Monday morning and Thursday afternoon**
EDD	**EDD**	**Expected Delivery Dates**	

EHR	**EHR**	**Electronic Health Record**	**Health information about a patient collected in digital format which can theoretically be shared across different healthcare settings**
ENP	**ENP**	**Emergency Nurse Practitioner**	**Specialist A&E nurse**
EOC	**EOC**	**Exec on Call**	
EPR	**EPR**	**Electronic Patient record**	
ESR	**ESR**	**Employee Staff Record system**	**HR system in use**
FOI	**FOI**	**Freedom of Information**	**The right to ask any public sector organisation for the recorded information they have on any subject**
Formulary		**Formulary**	**Approved NHS list of prescribed drugs**
FP10	**FP10**		**Forms used to prescribe drugs to outpatients that they can pick up at the hospital pharmacy, rather than having to pay themselves**
Francis Report		**Francis Report**	**report into Mid Staffs hospital**
FT	**FT**	**Foundation Trust**	**A part of the NHS in England that provides healthcare to patients/service users and has earned a degree of operational and financial independence**
FTE	**FTE**	**Full Time Equivalent**	**A measurement of an employees workload against that of someone employees full time e.g. 0.5 FTE would be someone who worked half the full time hours.**
FTGA	**FTGA**	**Foundation Trust Governors' Association**	**National membership association for governors of NHS foundation trusts**
FTN	**FTN**	**Foundation Trust Network**	**The membership organisation and trade association for the NHS acute hospitals and community, mental health and ambulance services that treat patients and service users in the NHS**

FY	**FY**	**Financial Year**	**The year used for accounting purposes, in the UK from 6 April to 5 April**
GMC	**GMC**	**General Medical Council**	**The independent regulator for doctors in the UK**
GI	**GI**	**Gastrointestinal**	
GMS	**GMS**	**General Medical Services**	
GP	**GP**	**General Practitioner**	**Doctor who provides family health services in a local community**
Green		**Green**	**Projects will be assessed as having an overall risk rating of green where it is considered that the project is delivering to plan in respect of progress and/or impact.**
GUM	**GUM**	**Genito-unitary medicine**	**For sexually transmitted diseases/infections**
HCA	**HCA**	**Healthcare Assistant**	**staff working within a hospital or community setting under the guidance of a qualified healthcare professional**
HCAI	**HCAI**	**Healthcare Associated Infection**	**These are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile are both classed as HCAIs**
Healthwatch		**Healthwatch**	**Local independent health and social care critical friend**
HEE	**HEE**	**Health Education England**	**the NHS body responsible for the education, training and personal development of staff**
HR	**HR**	**Human Resources**	**the department which looks after the workforce of an organisation e.g. Pay, recruitment, dismissal**
HSCA	**HSCA**	**Health and Social Care Act 2012**	**an Act of parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors**
HSDU	**HSDU**	**Hospital Sterile Decontamination Unit**	**Part of Clinical Support Services CSU**

HSMR	**HSMR**	**Hospital Standardised Mortality Rate**	**Number of deaths which is compared with other trusts**
HWB/HWBB	**HWB/HWBB**	**Health and Wellbeing Board**	**a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector**
IBP	**IBP**	**Integrated Business Plan**	**a strategy for connecting the planning functions of each department in a trust to align operations and strategy with financial performance**
ICU	**ICU**	**Intensive Care Unit**	**specialist unit for patients with severe and life threatening illnesses**
Intrapartum		**Intrapartum**	**During childbirth (as opposed to pre-natal and post-natal)**
IBP	**IBP**	**Integrated Business Planning**	
IG	**IG**	**Information Governance**	
IP	**IP**	**Inpatient**	**a patient who is hospitalised for more than 24 hours**
IT	**IT**	**Information Technology**	**the study or use of systems(especially computers and telecommunications) for storing, retrieving and sending information**
Keogh Reviews		**Keogh Reviews**	**Reviews of Hospitals led by Sir Bruce Keogh, originally targeted hospitals with high mortality rates.**
Kings Fund		**Kings Fund**	**independent charity working to improve health and care in England**
KPIs	**KPIs**	**Key Performance Indicators**	**indicators that help an organisation define and measure progress towards a goal**
LD	**LD**	**Learning Disabilities**	**a disability which affects the way a person understands information and how they communicate**
LETB	**LETB**	**Local Education and Training Board**	**these are the local arms of Health Education England, now called by their region rather than LETB - e,g, training and workforce issues**

LHE	**LHE**	**Local Health Economy**	**the supply and demand of health care resources in a given area and the effect of health services on a population**
LOS	**LOS**	**Length of Stay**	**a term commonly used to measure the duration of a single episode of hospitalisation**
MDP	**MDP**	**Maternity Development Plan**	
MHA	**MHA**	**Mental Health Act**	**the law in England and Wales that allows people with a 'mental disorder' to be admitted to hospital , detained and treated without their consent - either for their own health and safety, or for the protection of other people**
MI	**MI**	**Major Incident**	**a major incident affects, or can potentially affect, hundreds or thousands of people and can cause a significant amount of casualties e.g. closure of a major facility due to fire, or persistent disruption of services over several weeks/months**
MIU	**MIU**	**Minor Injuries Unit**	**somewhere you can go to be treated for an injury that's not serious instead of going to A & E, e.g. For sprains, burns, broken bones**
MKUHFT	**MKUHFT**	**Milton Keynes University Hospital Foundation Trust**	**Abbreviation of Milton Keynes University Hospital NHS Foundation Trust**
MKUCS	**MKUCS**	**Milton Keynes Urgent Care Centre**	**Consortium with GPs (40% owned by Trust) based in the hospital to alleviate A&E**
MOC	**MOC**	**Manager on call**	
Monitor		**Monitor**	**Regulatory Body "Independent' organisation to monitor foundation trusts**
Morbidity		**Morbidity**	**the proportion of sickness or of a specific disease in a geographical locality.**
Mortality		**Mortality**	**the relative frequency of deaths in a specific population; death rate.**
MoU	**MoU**	**Memorandum of**	

		Understanding	
MRI	**MRI**	**Magnetic Resonance Imaging**	**a medical imaging technique**
MRSA	**MRSA**	**Methicillin-Resistant Staphyloccus Aureus**	**a bacterium responsible for several difficult-to-treat infections in humans**
MSA	**MSA**	**Mixed Sex Accommodation**	**wards with beds for both male and female patients**
MUST	**MUST**	**Malnutrition Universal Screening Tool**	**MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.**
NE	**NE**	**Never Event**	
NED	**NED**	**Non Executive Director**	
NHS	**NHS**	**National Health Service**	**publicly funded healthcare system with the UK**
NHS Direct	**NHS Direct**	**NHS Direct**	**24-hour telephone helpline and website providing confidential information on health conditions local healthcare services, self help and support organisations**
NICU	**NICU**	**Neonatal Intensive Care Unit**	
NHSLA	**NHSLA**	**NHS Litigation Authority**	**Manages Clinical Negligence Scheme for Trusts**
NHSTDA	**NHSTDA**	**NHS Trust Development Authority**	**provide governance and accountability for NHS trusts in England and delivery of the foundation trust pipeline**
NICE	**NICE**	**National Institute for Health and Care Excellence**	**provides national guidance and advice to improve health and social care**

NMC	**NMC**	**Nursing and Midwifery Council**	**nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands**
NPSA	**NPSA**	**National Patient Safety Agency**	
NRLS	**NRLS**	**National Reporting and Learning System**	**Database for recording patient safety incidents (held by MPSA)**
NSfs	**NSFs**	**National Service Frameworks**	**set clear quality requirements for care**
OP	**OP**	**Outpatients**	**a patient who is not hospitalised for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment**
OSCs	**OSCs**	**Overview and Scrutiny Committees**	**established in local authorities by the Local Government Act 2000 to develop and review policy and make recommendations to the council**
PA	**PA**	**Programmed Activities**	**4 hour blocks that are used to make up a consultant's contract.**
PALS	**PALS**	**Patient advice and liaison service**	**You can talk to PALS who provide confidential advice and support to patients, families and their carers, and can provide information on the NHS and health related matters.**
PbR	**PbR**	**Payment by Results or 'tariff'**	**a way of paying for services that gives a unit price to a procedure**
PDR	**PDR**	**Personal Development Review**	**Appraisal system**
PFI	**PFI**	**Private Finance Initiative**	**a scheme where private finance is sought to supply public sector services over a period of up to 60 years**
PLACE	**PLACE**	**Patient-Led Assessments of the Care Environment**	**local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food cleanliness and general building maintenance**
POA	**POA**	**Pre-operation assessment**	

PPI	**PPI**	**Patient and Public Involvement**	**mechanisms that ensure that members of the community - whether they are service users, patients or those who live nearby - are at the centre of the delivery of health and social care services**
PROM	**PROM**	**Patient Reported Outcome Measures**	
Productive Ward		**Productive Ward**	**Initiative to streamline operation of wards - included in Maternity Development Plan, due to be rolled out across the hospital**
PTS	**PTS**	**Patient Transport Services**	**free transport to and from hospital for non-emergency patients who have a medical need**
QA	**QA**	**Quality Assurance**	**monitoring and checking outputs and feeding back to improve the process and prevent errors**
QGAF	**QGAF**	**Quality Governance Assurance Framework**	**assess the combination of structures and processes in place, both at and below board level, which enable a trust board to assure the quality of care it provides**
QIPP	**QIPP**	**Quality, Innovation, Productivity and Prevention**	**12 work streams to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements.**
Quality Accounts		**Quality Accounts**	**An annual report to the public from providers of NHS healthcare services about the quality of their services**
RAG	**RAG**	**Red, Amber, Green classifications**	**a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)**
RCA	**RCA**	**Root cause analysis**	
RCGP	**RCGP**	**Royal College of General Practitioners**	**professional membership body for GP's**

RCP	**RCP**	**Royal College of Physicians**	**professional membership body for doctors**
RCS	**RCS**	**Royal College of Surgeons**	**professional membership organization representing surgeons**
R&D	**R&D**	**Research & Development**	**developing new products or processes to improve and expand**
Red		**Red**	**Projects will be assessed as have an overall risk rating of red where it is considered that the project is not being delivered as planned in respect of progress and/or impact.**
RGN	**RGN**	**Registered General Nurse**	**a nurse who is fully qualified and is registered with the nursing and Midwifery Council as fit to practice**
RTT	**RTT**	**Referral to treatment**	**Used as part of the 18 week indicator**
Rule 43		**Rule 43**	**Issued by Coroners to organisations. Must be responded to within 56 days. Lord Chancellor's office keep a record of all rule 43s issued**
SFI	**SFI**	**Standing Financial Instructions**	**Found on the intranet under 'Trust Policies'**
SHMI	**SHMI**	**Summary Hospital Level Mortality Indicator**	**reports mortality at trust level across the NHS in England using standard and transparent methodology**
SI	**SI**	**Serious incident**	**A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care**
SID	**SID**	**Senior Independent Director**	**a non executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair**
SIRG	**SIRG**	**Serious incident Review Group**	**to review serious incidents and identify learning points**
SLM	**SLM**	**Service Line Management**	**A framework for the delivery of clinical services**
SLA	**SLA**	**Service Level**	**an agreement between two or more**

		Agreement	**parties**
SLR	**SLR**	**Service Line Reporting**	**A reporting system which by comparing income against expenditure gives a statement of profitability at service line level**
SRR	**SRR**	**Significant risk register**	**Risks scored 15 and over**
SSA	**SSA**	**Same sex accommodation**	
T&C	**T&C**	**Terms and conditions**	**set the rights and obligations of the contracting parties, when a contract is awarded or entered into**
TDA	**TDA**	**Trust Development Authority**	**Regulator for Non foundation trusts**
T&O	**T&O**	**Trauma & Orthopaedics**	
TRR	**TRR**	**Trust risk register**	
TTO	**TTO**	**To Take Out**	**Medicines given to discharging patients**
VTE	**VTE**	**Venous thromboembolism**	**Blood clotting, usually caused by inactivity. Should be assessed for routinely to ensure care pathways take into risk**
WiC	**WiC**	**Walk in Centre**	**Provided jointly with the hospital and local GPs under a commercial arrangement as the Urgent Care Centre**
WTE	**WTE**	**Whole time employees**	**Member of staff contracted hours for full time**
YTD	**YTD**	**Year to Date**	**a period, starting from the beginning of the current year and continuing up to the present day. The year usually starts on 1st January**