Milton Keynes University Hospital NHS
NHS Foundation Trust

QUALITY ACCOUNTS 2016-2017

Part 1: The Quality Account

1.1 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 we provide to our patients during 2016/17; as well as to identify where we will focus our efforts next year to make the care and experience we provide as safe, positive and effective as it can be.

Each year we set our objectives as a hospital and each year our top three objectives are improving patient safety, improving patient experience and improving clinical effectiveness. Those three aims remain at the heart of everything we do and everything we are here to deliver every day, for every one of the hundreds of thousands of people we care for every year.

It has been an exciting year of developments at the hospital, with the Trust investing in the development of staff, our services and the estate itself to improve both the quality and capacity of care we offer the people of Milton Keynes and surrounding areas.

We opened a new 20-bed surgical ward in February 2017 to help us address the ever-increasing demand for our services and began construction on a new main entrance – due to open in June 2017 – which will enable us to accommodate the greater number of visitors who will be coming to the hospital this year.

As well as these improvements to the site, building has also started on a new Academic Centre at the start of the year. The construction is a result of our partnership with the University of Buckingham Medical School, who are funding its development, and will provide an outstanding education resource with facilities to train medical students, doctors, nurses and health professionals working across the hospital.

More good news came in the form of a 'Good' rating following an inspection by the Care Quality Commission (CQC) in June 2016. It marked a significant improvement to our last CQC rating of 'Requires Improvement' two years prior and recognised the Trust as being effective, caring, responsive and well-led.

Demand on the hospital's services continued to increase during 2016/17. We received 11% more GP referrals than had been planned for, and demand on Accident & Emergency was also 3% higher than in 2015/16. The impact of the increase in demand has been that the Trust has accommodated a growing number of emergency admissions, and treated over 1,500 more elective admissions than planned at the start of the year.

Despite the increase in demand on its services, the Trust has successfully reduced waiting times for planned patients during 2016/17, and the national standard for

consultant-led Referral to Treatment Waiting Times was successfully delivered for five consecutive months. The national standard for diagnostic waiting times also achieved for the whole of the second half of the year. Performance against cancer treatment standards has proved a challenge but significant improvements were made in the final quarter of 2016/17.

I look forward to another year of developing and continuing to improve our hospital and the care we provide for the people of Milton Keynes.

1.2 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.

The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to the best of my knowledge, the information in the document is accurate.

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

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Joe Harrison

Chief Executive

May 2017

1.3 Introduction

This report provides an overview of performance across our key priorities and illustrates our commitment to providing a quality service for patients.

It also outlines our planned measures for assuring and sustaining our performance for the future. This includes recognition that there are areas which require improvement.
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 a fast-growing population. The hospital provides services for all medical, surgical, maternity and child health emergency admissions.

In addition to delivering general acute services, Milton Keynes University Hospital increasingly provides more specialist services, including cancer treatment, cardiology and oral surgery. It also has responsibility for treating premature babies born locally and in the surrounding areas.

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, and this helps us to tackle issues as they arise.

As well as our staff, we are also proud of our strong relationships with our stakeholders. The involvement of patients, the public, governors, local information networks, and health 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 enthusiasm and commitment to fulfilling their role as elected representatives of patients and the public, through their direct activity with the community as well as their participation in Milton Keynes Healthwatch meetings and other community forums. An elected governor also attends meetings of the Quality and Clinical Risk Committee which

monitors performance of the hospital against the quality priorities set in the Quality Account.

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.

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Part 2 Our priorities

2.1 Priorities for Improvement

Introduction

Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement.

The purpose of the Quality Accounts 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 providers to report on the improvements to their services and to set out their priorities for the following year.

As part of our quality account for 2017/18 the Trust is required to choose at least three quality priorities for the year to be included within Part 2 of our Quality Accounts.
There are criteria for choosing these priorities, which are:

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

Once agreed the Quality Account must report upon how progress to achieve the priorities is identified, including how they will be monitored and measured and how they will be reported by the Trust.

Our Priorities for 2017/18

The following priorities identified have been shared with, and agreed by our governors.

2.2 Trust Objective 1 – Improving Patient Safety

1. Improving the management of patients with sepsis via delivery of the national CQUIN
2. Delivering the Saving Babies Lives Care Bundle in maternity
3. Improving the patient experience through staff engagement
4. Reducing length of stay

2.3 Quality Indicator 1: Improving the management of patients with sepsis via delivery of the national CQUIN

Sepsis is the leading cause of death in hospitals worldwide. The incidence of sepsis is increasing, likely in part to be due to an ageing population who are more at risk of infection. The UK Sepsis Trust estimates that over 12,500 lives per year could be saved if sepsis is recognised and treated in its early stages. Early identification and treatment is key to reduction in death from sepsis. 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'.

The Trust has worked very hard in 2016/17 to improve sepsis care in line with best practice and this will continue in 2017/18.
During the year we were measured against these standards via the national CQUIN:

- Every patient who attends one of our emergency areas must have a sepsis assessment and, if they are identified as having sepsis, they must be given antibiotics within 1 hour. The national minimum target is 50%
- Every patient identified as having sepsis in an inpatient setting must be given antibiotics within 1 hour. The national minimum target is 50%

As part of NHS England's CQUIN indicators for Sepsis the Trust reported against the timely identification and treatment for sepsis in Emergency Departments and Acute Inpatient settings respectively. As a result of the sampling methods used to measure performance against CQUIN indicators, the Trust has not met the quarterly targets required for these CQUIN's We believe that this is due to a mixture of non-compliance with the protocol and continued difficulties collecting the data.
Our performance was 33%

Sepsis has received trust wide attention and has been the focus of a specific working group which is chaired by the Associate Medical Director Lead for Patient Safety, with MKUHFT also being represented at the Oxford Academic Health Network Sepsis Steering Group. The MKUHFT Sepsis working group is multidisciplinary including sepsis leads for each clinical division as well as representatives from Clinical Governance, Management, Nursing, Education, Transformation and Communications. During the year the MKUHFT working group has developed and supported the introduction a new proforma across the adult admission and inpatient areas and is in line with recent NICE guidance and the UK Sepsis Trust. Sepsis boxes have been introduced across the organisation including maternity areas.

These boxes contain all of the equipment and documentation to implement the Sepsis six.

There is an increasing level of training being rolled out across the organisation with training included in the Trust induction programme, and bespoke sessions, which have included maternity and the Emergency Department. Sepsis training has been identified by the Sepsis group to be extended across the organisation in 2017/18.

Work has been ongoing to increase awareness of sepsis to both staff and our patients. Patient and relative information and communications leaflets have been introduced with information reflecting the national guidance. Staff awareness has included sepsis scenarios used in Simulation Acute Medicine training which is multi professional and enables doctors and nurses understand the practical processes involved with identification and management of sepsis.

A new trust guideline is currently in development to ensure all staff have ready access to the in-house expectations for sepsis treatment and care pathways, and will link together all the improvements the Sepsis Working Group have established this year. In addition all deaths from sepsis are reviewed to ensure that all correct steps in the patients care had been taken.

2.4 Quality Indicator 2: Delivering the Saving Babies Lives Care Bundle in maternity
Measurement – a 90% completion of the 'fresh eyes' process on the Labour ward

Saving Babies' Lives Care Bundle is designed to tackle stillbirth and early neonatal death. It 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

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.

As a Trust we are undertaking all four elements of the saving lives bundle, one of the few Trusts in the country to do so. For our quality priorities we are focussing on the care bundle about 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). This trace gives us 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'. We measure how well our labour ward completes the 'fresh eyes' reviews every hour and we report on this every month. We believe that this is a key intervention to deliver the care bundle and it is also an area that we can make improvements and so we have chosen this as a priority.

2.5 Quality Indicator 3: Improving the patient experience through staff engagement

Measurement – Three marks improvement in the staff survey key finding of "Staff recommendation of the trust as a place to work or receive treatment"

The quality of patient experience, as measured by inpatient satisfaction in acute trusts, is strongly linked with engagement (as it is with other aspects of staff experience). Patient satisfaction is significantly higher in trusts with higher levels of employee engagement. Research conducted by Professor Michael West of Aston Business School, have been able to establish a connection between levels of staff engagement and patient experience through the results of the staff survey data and other performance data.

Each year NHS staff are invited to take part in the NHS Staff Survey, the largest survey of staff opinion in the UK. Staff are sent a questionnaire asking about many different aspects of working experience including appraisal and development; health and wellbeing; raising concerns and staff engagement and involvement.

The staff engagement element of the survey looks at the three dimensions of engagement: the levels of motivation and satisfaction; involvement and willingness to be an advocate of the service. The scores across all three dimensions are converted into an overall staff engagement score, which is an index of staff engagement in the Trust.
Michael West's research shows that where staff engagement scores are high, scores are also significantly higher for patient satisfaction.

"Staff recommendation of the trust as a place to work or receive treatment" finding forms part of the staff engagement score and is also seen as important indicator of staff confidence in the quality of care. There is evidence from analysis of the staff survey that links high scores on staff recommendation of the organisation as a place to work with patient satisfaction.

The trust's overall staff engagement score of 3.81 out of 5 (the higher the better) remained unchanged since 2015 and was average when compared with trusts of a similar type. However, the key finding of "staff recommendation of the trust as a place to work or receive treatment" decreased slightly from last year to 3.74 and is marginally below the national average of 3.77.

Given the importance of this key finding in improving patient experience, the trust seeks to increase its rating by three marks to 3.77.

With this renewed focus on staff engagement in the Trust, it has adopted a range of initiatives and interventions to support improved staff engagement and have a positive impact on patient experiences. This includes "You Said, We Did" campaign – which addresses the areas for improvement from the results of the survey; staff health and wellbeing initiatives, Schwartz rounds, value based appraisals and in May 2017 the first Event in the Tent.

The core concept of the Event in the Tent is to provide a forum where the trust can encourage and increase participation amongst staff and invite them to share their views on the Trust including improvements in patient experience and staff experience. With the recent CQC rating of Good, the Trust is now looking at ways in which it can achieve an 'Outstanding' rating and how we can support our staff in realising this ambition. This involves developing an open culture where staff feel confident to challenge our current ways of working and also looking at the health and wellbeing of staff to create a happier, healthier workforce.

It is envisaged that with this increased focus on staff engagement will result in an overall slight increase in the key finding. The key finding will be reported in the next staff survey. However, the scores will be monitored quarterly as part of the staff friends and family test reports.

2.6 Quality Indicator 4: Reducing the length of stay

Measurement: - A 5 percent increase in the number of patients discharge before midday.

Every hospital faces growing demand for services and all are looking for ways to improve patient experience and promote safe and timely discharge and reduce length of stay. Ensuring that patients don't stay in hospital for any longer than is clinically necessary improves quality of care, prevents patients becoming deconditioned and supports freeing up of capacity in the system.
Nationally there is a real drive to for hospitals to embed the Red: Green Bed days and the SAFER patient flow bundle and we are in the process of implementing these tools. All of these actions together should assist us in discharging patients more safely and more quickly.

Red: Green Bed days

Red: Green days is a visual system to assist hospitals in the identifying wasted time in a patient's journey and can be applied to in-patient wards in both acute hospital and community settings. At the centre of this concept are patients and their involvement in setting the expectation of what will be happening as part of their care in hospital. These 4 simple questions should be asked as soon as possible after their arrival at hospital.

1. **Do I know what is wrong with me or what is being excluded?**

2. **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)
3. **What do I need to achieve to get home?** (The 'clinical criteria for discharge', which is a combination of 'physiological and 'functional' factors)
4. **If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?**

   Lack of clarity to the answers to any of these 4 questions often results in 'hidden waiting' which creates frustration and confusion for the patient.

A Red Bed Day is defined as a day when the patient is not in receipt of 'care' that is required to be delivered as an in-patient. With the key question – 'what is this patient waiting for to progress to the next phase of their care?' It is not simply that something is happening that makes it a Green Bed Day, it only becomes a Green Bed Day if that process/test/procedure could only happen as an in-patient for that particular patient's circumstances on that day. The day remains a Red Bed Day until the result of the investigation/ test is acted upon. Red days for patients often occur at weekends and Bank Holidays. Overall Red and Green days support in proactively identifying delays and resolving those to improve patient care and deliver improved flow.

SAFER Patient flow bundle

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 bundle consists of 5 elements of best practice. It's important that all 5 elements implement all five elements together to achieve cumulative benefits. The SAFER patient flow bundle works particularly well when it is used in conjunction with the 'red & green days' approach.

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.

2.7 Additional indicators

In addition to the 4 priorities given above the Board considers three indicators in Patient experience and Clinical Effectiveness which it monitors on a monthly basis to provide an overview of care delivered by the Trust. These indicators support the delivery of the Trust objectives which the Board has consulted the organisation and governors on.

2.7.1 Clinical Effectiveness

Patients Discharged at the weekend
The Trust has made significant investment in additional doctor's rounds at the weekend to facilitate discharge as this is when patient flow is at its most challenging. Our performance on this issue has been particularly good in the second half of the year since the investment was made

Numbers of delayed transfers of care
A delayed transfer of care occurs when a patient is medically fit for discharge but is waiting for a place to go home to – this may be their own home with a package of care, or a residential or nursing home. The Trust is working with our partners to improve discharge for our patients, and the Board continues to monitor this indicator, as it has not been met at any point this year.

Discharges from our Patient Discharge unit
The Trust has concentrated getting patients to our discharge lounge as soon as possible on the day of going home as it allows us to admit both emergency and planned patients much more quickly to the wards.

Patient Experience

Friends and Family Test recommend rates from patients. In 2016/17 the Trust's performance was 93%. The Friends and Family test is a national indicator which can be used to assess the Trust's performance against other organisations. In addition, the performance from different areas of the hospital is reviewed and action taken to address lower scores.

Response to Complaints within agreed timescales.
In 2016/17 the performance was 80**%** of complaints responded to within the agreed time against a target of 90%. The PALS and Complaints team is working with individual services to improve the timeliness of responses to complaints.

Over 75 year old patient ward moves at night
In 2016/17 over 1,800 patients over 75 years old were moved after 10pm at night. The Board recognise that wherever possible any such moves should be minimised, but that at times it is necessary to move patients to a bed in a more appropriate care location.

Part 3 How we did last year 2016/2017

3.1 Priority 1

Improve systems to reduce the frequency and severity of medication errors

There was an improvement in the reporting of medication errors in 2015/16 following a local CQUIN. The Trust subsequently chose to build on these improvements and further reduce the frequency and severity of medication errors. The approach taken focused on improving medication safety by reviewing and improving the systems used, principally the introduction of the national medication safety thermometer which provided a system for collecting data and a baseline to highlight areas for improvement.

MKUH has been collecting and uploading this data to the national tool, but since January 2017 the Trust has been unable to extract this data due to management and support arrangement changes at a national level. The ownership of the data has now changed to NHS South, Central and West Commissioning Support Unit and plans are in place to revise and relaunch.

Quarter 1 of the year was used to identify resource and agree processes for effective data collection. Test data was submitted in May and June, and monitoring started in July and ceased in quarter 4 for the reasons set out above.

The latest data MKUH holds is from November 2016 and shows:

a) The proportion of patients who had medication checked by a pharmacist within 24 hours of admission:
   - Average of 80% achieved. The possibility of raising this percentage depends on changes to weekend working and the introduction of additional pharmacy ward presence.

b) The proportion of patients who have had an omitted dose in the last 24 hours:
   - Medication Safety Thermometer - November data - 11% achieved. This proportion has reduced from a high of 13.5%. Work has been undertaken to improve medication storage on the wards, ensuring the medicines can be located by staff more easily.

c) The proportion of patients with medicine allergy status documented:
   - Medication Safety Thermometer - November data - 100%.

d) The proportion of patients with an omission of critical medicines:

- Medication Safety Thermometer - November data - 16%. There was a significant increase in October / November due to the unavailability of a key antibiotic as a result of a manufacturing problem - the average for the year was 6.8%. Antibiotic guidelines have now been reviewed to ensure that we have the necessary medicines available.

e) The proportion of patients receiving a high risk medication in the last 24 hours
   - Medication Safety Thermometer - November data - 39% against an average of 30%. This reflects the increase in antibiotic use in the winter months.

f) The proportion of patients on a high risk medication that trigger a multi-disciplinary team (MDT) referral:
   - Medication Safety Thermometer - November data - 1% which is higher than the 0.4% average due to the increase in use of critical medicines in the winter.

The focus this year was on setting up the process for recording as part of the medication safety thermometer, safe storage of medicines, ensuring they can be located, that medicines are available when and where they are needed and the appropriate use of antibiotics.

A service improvement project titled “The Safe and Secure Handling of Medication on Ward based Drug Trolleys” conducted by Anum Ahmed, a pre-registration pharmacist, won the regional Pre-Registration Project competition, and has been key to improving the safe use of medicines on our wards.

3.2 Priority 2
Embed the new processes for the identification and management of the deteriorating patient

Early identification of clinical deterioration is important in preventing subsequent cardiopulmonary arrest and reducing mortality. However, sometimes patients’ conditions deteriorate before staff are able to recognise and respond to the signs. This highlights the complexity in seeking to consistently and effectively detect and act on patient deterioration.

Following the investment in digital technology to assist in the collection of clinical observations (blood pressure, pulse, oxygen saturation levels) the Trust has embedded the use of the National Early Warning Score (NEWS) charts. Education and training was introduced in 2014/15 and has continued into 2016/17. This training is run in conjunction with the Rapid Response Team and embeds the Level 1 pathway (the pathway of care for acutely unwell patients). The Level 1 pathway was modelled on a successful initiative on the hospital’s paediatric wards, providing enhanced medical and nursing oversight of patients who might deteriorate, and promoting early decision-making and communication with the patient and family.

Data continues to be captured via the nursing metrics about the taking and recording of clinical observations and the appropriate escalation of observations outside normal parameters. This year the metrics had the additional requirement for staff to document the frequency of the observations needed as well as reporting the actual completion of observations undertaken. This additional indicator was added to improve the recognition of the changing needs of the deteriorating patient, including altering the frequency of observations needed, and ensuring this is communicated effectively between staff and teams involved in the care of a patient.

The Trust target for achievement of patient observations undertaken at the frequency indicated is 95% (Q1 in the table below) with current Trust wide performance (March 2017) being reported as 92%, an improvement from the 90% recorded in March 2016.

The Trust target for documenting the NEW score is 90% (Q2 in the table below), and current performance (March 2017) is at 93%, maintaining the levels achieved in 2015/16.

Trust wide nursing metrics for recognising the deteriorating patient:
Q1 Have patient observations been undertaken at frequency indicated?
Q2 Has the NEW score been documented?

	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Q1	95%	90%	90%	69%	85%	86%	91%	93%	92%	91%	92%	92%	92%
Q2	90%	93%	93%	95%	92%	94%	93%	93%	92%	94%	93%	93%	93%

The Rapid Response (RR) service captures data about patients on the daily caseload and provides regular reports to Clinical Quality Board. Since the introduction of the L1P the number of patients on the pathway has risen steadily. Baseline data from before the introduction shows that the number of deteriorating patients on the RR caseload in the hospital has more than doubled. The pathway has been adopted for maternity patients in February 2017, and the RR service will continue to capture activity data to track the use of the L1P in the hospital and present their findings to both the Nursing and Midwifery Board and the Clinical Board, to review recommendations and support the embedding of the new system.

3.3 Priority 3
Improve the management of patients with sepsis

We have reported against our management of patients with sepsis this year as this target has been rolled over.

3.4 Statement of Assurance from the Board of Directors

During 2016/17 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 2016/17 represents 100% of the total income generated from the provision of relevant health services by Milton Keynes University Hospital NHS Foundation Trust for 2016/17.

3.5 Obstetrics and Maternity Services

The Trust has continued its monitoring of improvements in obstetric and maternity services and was pleased by the 'good' rating from the CQC following inspection during the year. The maternity improvement board continues to meet and drive through quality changes for the benefit of the women and children in our care.

3.6 Referral to Treat (RTT) 18 week pathway

Despite treating significantly more patients than during the previous year, the Trust has successfully reduced waiting times for patients. Against the NHS Improvement recovery trajectory agreed at the beginning of 2016/17, consultant-led referral to treatment waiting times have consistently delivered in the second half of the year.

The national standard of 92% has also been achieved consistently since November 2016:

Month 2016/17	NHSI Trajectory	Trust Performance
April	88.0%	88.0%
May	88.5%	88.5%
June	88.2%	87.4%
July	89.2%	88.7%
August	89.5%	88.8%
September	90.3%	89.9%
October	90.6%	91.7%
November	91.5%	93.1%
December	92.2%	92.6%
January	92.3%	92.5%
February	92.4%	92.5%
March	92.5%	92.5%

3.7 Review of Clinical Audits

The Trust is committed to delivering effective clinical audit in all clinical services it provides. The Trust sees clinical audit as a cornerstone of its arrangements for developing and maintaining safe, high quality patient-centered services. The Trust

clinical governance and compliance assurance mechanisms provide opportunities to:

- Provide assurance of compliance with clinical guidelines and standards;
- Identify and minimise risk, waste and inefficiencies;
- Improves the quality of care and patient outcomes.

We are committed to participating in relevant National Confidential Enquiry to help assess the quality of healthcare nationally and to bring about improvements in safety and effectiveness.

During this period MKUH participated in 31 (79%) eligible National Clinical Audits which met the Quality Accounts inclusion criteria.

Participated eligible	31
Not participated	7
Not applicable	10

The Trust participated in 5 National Confidential Enquiry into Patient Outcome and Death studies.

National Confidential Enquiry into Patient Outcome and Death Study Eligible 2016-17	**Participated**	**Cases Submitted**
Mental Health	Yes	5
Acute Pancreatitis	Yes	5
Acute Non Invasive Ventilation	Yes	4
Chronic Neuro disability	Yes	2
Young People's Mental Health	Yes	2
Cancer in Children, Teens and Young Adults	No – no cases identified	

National Audit Participation 2016-17	**Number of cases submitted**
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	111
Adult Asthma	Not available

Asthma (paediatric and adult) care in emergency departments	Not available
Bowel Cancer (NBOCAP)	426
Cardiac Rhythm Management (CRM)	Not available
Case Mix Programme (CMP)	453
Diabetes (Paediatric) (NPDA)	125
Elective Surgery (National PROMs Programme)	Not available
Falls and Fragility Fractures Audit programme (FFFAP)	549
Inflammatory Bowel Disease (IBD) programme	53
Learning Disability Mortality Review Programme (LeDeR Programme)	4
Major Trauma Audit	266
Maternal, Newborn and Infant Clinical Outcome Review Programme	Not available
National Audit of Dementia	55
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	41
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	17
National Diabetes Audit - Adults	44
National Emergency Laparotomy Audit (NELA)	105
National Heart Failure Audit	354
National Joint Registry (NJR)	
National Lung Cancer Audit (NLCA)	143
National Prostate Cancer Audit	392
Neonatal Intensive and Special Care (NNAP)	449
Nephrectomy audit	Not available
Oesophago-gastric Cancer (NAOGC)	44
Paediatric Pneumonia	20
Percutaneous Nephrolithotomy (PCNL)	Not available
Renal Replacement Therapy (Renal Registry)	8305
Sentinel Stroke National Audit programme (SSNAP)	207
Stress Urinary Incontinence Audit	Not available
UK Cystic Fibrosis Registry	21

The following audits which we were eligible but MKUHFT did not participate are:

National Cardiac Arrest Audit (NCAA)	Trust runs own audit using same tool as national audit
National Ophthalmology Audit	Software issues
National Vascular Registry	Vascular service is run from Bedford
Rheumatoid and Early Inflammatory Arthritis	Departmental pressures meant the team were unable to complete the second audit
Head and Neck Cancer Audit	Care is shared with Northampton hospital
Endocrine and Thyroid National Audit	Care is shared with Northampton hospital
Severe Sepsis and Septic Shock – care in emergency departments	Trust participating in local CQUIN

There were 11 national audit reports published and reviewed during this period

National Bowel Cancer Audit

Colorectal (large bowel) cancer is the most common cancer in non-smokers and second most

common cause of death from cancer in England and Wales. Each year over 30,000 new cases are diagnosed, and bowel cancer is registered as the underlying cause of death in half of this number.	
Recommendation(s) Discussion points and actions points we intend to take	
1.	Continue current work on improving data collection and upload
2.	Audit data on circumferential resection margins for rectal cancer patients

Actions points carried forward onto forward audit plan for 2017-18.

National Clinical Audit of biologic therapy in Inflammatory Bowel Disease	
Recommendation(s)/Outcomes Discussion points and action points we intend to take	
1.	All patients will continue to be discussed in IBD Multidisciplinary Team to decide if Biologic therapy is appropriate.
2.	Continue screening patients before the biologic therapy
3.	Book a follow up clinic appointment at 3 months from 1st dosage for review of their disease activity
4.	Continue to use Biosimilars

Actions are being taken forward through the Medicine Clinical Improvement Group.

National Diabetes in Pregnancy	
The audit is a measurement system to support quality improvement in the care of women with diabetes who are pregnant or planning pregnancy, and seeks to address three key questions: • Were women adequately prepared for pregnancy? • Were adverse maternal outcomes minimised? • Were adverse fetal/infant outcomes minimised?	
Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Pre conception clinic
2.	Augmented care planning for pregnancy counselling
3.	Adequate dedicated Specialist Nurse support (currently only 2 days per week for pre conception, antenatal, post natal including pumps in pregnancy)
4.	Supported IT technologies – DIASEND, telehealth
5.	Audit current knowledge of pre pregnancy planning among patients
6.	Poster presentation in November local diabetes conference to highlight our performance

Actions are being taken forward collaboratively with Womens health and Medicine Governance groups.

National Heart Failure Audit
The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.
Recommendation(s)/Outcomes Discussion points and actions points we intend to take

1.	To improve coding, share with teams to use “diagnosis” rather than “?” or “impression”
2.	Partake in next annual audit
3.	Discuss with coding to come to audit afternoon in 2017 for education
4.	Business case for additional Advanced Nurse Practitioner; to preset at Management Board
5.	AHF pathway to improve referral to specialist for review
6.	Engage with community re overall pathway

Actions for the heart failure audit are tracked through the Cardiology Governance Meeting.

Stroke Sentinel National Audit Program (SSNAP)	
The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence based standards. These standards are informed by the National Clinical Guideline for Stroke, and national and local benchmarks.	
Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Need for improved adherence to agreed ring fenced bed policy
2.	Need to increase SALT provision for SRU.
3.	Need to review nurse numbers per shift.
4.	Need to involve patients and carers in evaluating care.

The Acute Stroke Audit actions are tracked at the quarterly quality meeting with Milton Keynes Clinical Commissioning Group and divisional dashboards.

Audit of Red Cells and Platelet Transfusion in Adult Haematology Patients	
The objective of this national audit was to examine the use of platelet transfusions against audit standards developed from national guidelines.	
Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Review local blood transfusion policy
2.	Review mandatory presentations
3.	Audit Blood Transfusion prescription requests
4.	Audit of platelet Transfusions
5.	Develop and publish local platelet guideline

Intensive Care National Audit and Research Centre Case Mix Programme

The Case Mix Programme (CMP) is an audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland.

Learning identified from report and recommendations:

1. Our acute hospital standardized mortality rates for unit survivors is within 2SD of the national mean and our SMR for those with predicted mortality <20% is less than the national average.
2. Our bed days of care >8 hour delay (i.e. delayed discharges from DoCC to ward) is still very poor and we are a national outlier in this respect
    a. **Recommendations and actions we intend to take**:
        i. This is given a far greater priority within the Trust at all levels, including executive, operational, nursing and medical.
        ii. DoCC is moved up priority list when ward beds become available. This should be highlighted at morning "safety huddle" and is especially important when the DoCC is at capacity and unable to accept emergency admissions
        iii. Improved use of L1P to identify sick patients who need L2/3 care and proactive movement of patients from DoCC to improve patient flow and safety.
        iv. Consideration to CQUIN to meet improved time-to-discharge. These remain available for negotiation but we are still too much of an outlier for this to be a financially viable option.
    b. Note: I have already met Head of Operations lead, to discuss this issue. In addition, this must be flagged up to executive level if any progress is to be made

What did we do well at in the Trust? i.e. better than the England average

1. Unit acquired infections
2. Out-of-hours discharges
3. Non-clinical transfers
4. SMR for patients with predicted mortality <20%
5. Data collection

Actions for the ICNARC audit are being taken forward through the Clinical Improvement Group for Surgery.

National vascular registry 2016

The National Vascular Registry is measures the quality and outcomes of care for patients who undergo major vascular surgery in NHS hospitals in England and Wales. It aims to provide comparative information on the performance of NHS vascular units and thereby support local quality improvement as well as inform patients about major vascular interventions delivered in the NHS. The measures used to describe the patterns and outcomes of care are drawn from various national guidelines including: the "Provision of Services for Patients with Vascular Disease" document and the Quality Improvement Frameworks published by the Vascular Society, and the National Institute for Health and Care Excellence (NICE) guidelines on stroke and peripheral arterial disease.

Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Difficult to extrapolate at MKUH – we don't do major arterial work here – it is all done in Bedford and with STP pathway will become centralised in Northampton shortly

No actions to be taken by Milton Keynes University Hospital Foundation Trust

National Neonatal Audit Programme	
Recommendation(s)/Outcomes Discussion points and actions points	
1.	To improve admission temperature by revising guidelines on usage of plastic bags for <34 weeks and education on resuscitation
2.	To improve administration of breast milk wihtin 24 hours of admission by allocating dedicated staff and resources- recruitment is in progress
3.	To improve number of babies on breast milk on discharge-

National Paediatric Asthma	
Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Education on assessment and management of asthma, wheeze and LRTI to doctors
2.	Education on the use of CXR and IV Abx
3.	Ensuring discharge advice provision and safety netting, usage of discharge stickers
4.	Review discharge criteria on the asthma guideline

National Paediatric Diabetes	
Recommendation(s)/Outcomes Discussion points and actions points we intend to take	
1.	Continue to focus resources on patients with high HbA1c – nurse led high HbA1c clinics.
2.	To employ a psychologist as part of the diabetes team to support children and families with diabetes – business case accepted and discussion with CAMHS underway to employ additional team member.
3.	To 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

There were **78** local clinical audits reviewed for this period. Below are examples of actions points we intend to take identified/taken to improve care.

Audit title	Key actions taken/we intend to take to improve patient care
Were all patients having had bowel surgery seen 1st day post op by a Physiotherapist?	Updated weekend patient sheet to include instructions to contact ward 20 either in person or by telephone to details of any new post-operative patients

Re-audit of fine needle aspirate	Local patient management guideline for fractured neck of femur updated to include standards for the transfer of patients from the Emergency Department to the Orthopaedic Ward within 2 hours of arrival.
Compliance of physiotherapy service in the stroke unit with NICE Guidelines	• Implementation of 7 day service for the physiotherapy team in the stroke unit. • Changed the prioritisation criteria for workload during the weekend
Tissue Retention Audit	100% of records were compliant with the standards set out in the MKHFT Records Management Policy and the Human Tissue Authority's Standards.
Competency of FY1 and FY2 doctors to interpret x-rays to confirm correct naso-gastric tube placement	• Registrar and above to interpret xrays within daytime hours • the on call radiologist will help interpret xrays which are difficult to interpret. • Ward poster for all ward areas. Naso gastric tube training on FY1 teaching programme.
Improving compliance with standards of record keeping in the in-patient physiotherapy services	• Written guidance produced for Physio staff re: expected standards for documentation • A common assessment proforma introduced for use in all ward areas excluding patients on ERP pathways
PSQ Pulmonary Rehab	• Meet with referrers to ensure that all making the referral explain to the patients why the referral has been made and that the ward patients are given the appropriate leaflet. Where this is not possible contact by email • To ensure at the time of the assessment that all patients are aware of the options that they are able to choose for their treatment and consent is gained.
Audit of histology reports of patients discussed and referred to the Cancer of Unknown Primary Multi disciplinary team	• Radiographer form re-emphasised. • Appropriateness of referrals feedback to Clinical Service Unit leads
Syphilis management at the Milton Keynes Sexual Health Centre	The development of a 'Reach –out' recall service for patients deemed particularly at high risk of acquiring a sexually transmitted infection.
Audit of Clostridium difficile clinical management	• Implementation of C diff management proforma as part of routine trust documentation • Availability of proforma on Intranet as part of C diff management pathway • Dissemination of information via local governance meeting, Trust audit awards, and presentation at National meeting (accepted for poster at Society of Acute Medicine conference in May) • Identification of juniors to continue data collection and re-audit for a 3rd loop

Heart Failure - a dangerous admission	• Documenting reasons for not initiating pharmacological treatment Heart failure MDT • Follow up with GP in immediate period • Improving discharge letters
Physiological monitoring & maintenance of homeostasis in acute stroke	• Stroke ward nurses trained in swallow assessment • Stroke pathway proforma includes a form to guide swallow assessment available in MAU and ED
Immune Thrombocytopenia (ITP) Management	• Raise awareness and education with team members • Review of the guideline for clarity with emphasis on documentation
Febrile Neutropenia Audit	• Availability of Nurses on unit who can access long lines in particular on PAU- to ensure that we have optimal number • Education for new and junior medical and nursing staff • Review of Oncology Pathway
Outcome of orthognathic cases using Patient At Risk scores	• All units met the Gold Standard for PAR outcomes for orthognathic cases • Average PAR reduction 83% • Treatment time / number of visits - no affect on PAR
Audit of the monitoring requirements of the Local Protocol for testing the hearing of parents and siblings of babies identified through the Newborn Hearing Screening Programme	• The 'Parent and sibling information request letter' has been updated • Protocol updated
Prescribing burden and paracetamol: can we stop to streamline discharge and save money?	To inform patients to ensure B&P are available at home when attending hospital for surgery
Emergency Thoracotomy: an update:	Series of teachings on emergency surgeries
Failed colonoscopy	Failure rate 6.3%.Main cause of failure is anatomy and looping. Patient with High BMI tend to fail more.
Antibiotic Prescribing in Appendicitis	• Update antibiotic protocol: include duration • .Increase awareness of hospital antibiotic guideline for appendicectomies: with more easily accessible guidelines, posters with antibiotic guideline in theatre, on surgical wards, in A&E • Encourage use of WHO Surgical Safety Checklist – to try ensure antibiotic prophylaxis given within the last 60 minutes prior to surgical procedure

Time to senior review for acute surgical referrals from the point of referral.	Clerking process more streamlined to ensure that patients are seen in a timely yet practical manner.
An audit on the quality/accuracy of emergency referrals from A&E	Outcome: We need collect our own data and then compare with college guidelines and see if we can adhere to them or should we be adhering to our MKUH targets of time taken to see patients
An audit of Urological readmissions Urology readmissions detailed assessment within a six mont period 1st September 2015 to 1st March 2016	Adjustment and refinement of post discharge protocol to avoid lack of advice on analgesia, where to get pain killers and advice to contact if problem rather hospital attendance.
Maternity VTE risk assessments	• Completion of postnatal VTE assessment form • Documented advice in handheld notes when to stop Low Molecular Weight Heparin • Prescription of TEDS on drugs chart • Correct advice regarding TEDS postnatally • Correct calculation of LMWH Dose
VTE risk assessment audit-Are we meeting RCOG standards?	• Booking form amendments to include multiple pregnancies. • .All high risk women should be seen in maternal medicine clinic. • Start LMWH from 1st trimester when indicated. • Improve documentation in handheld notes. • Documentation in handheld notes when to stop LMWH.
Audit of Percutaneous Breast Biopsies	• Standard by RCR (not specifically for breast biopsy – but for all image guided procedures): An adequate specimen from the biopsy site should be provided for histological/cytological assessment. Target: 95% • Audit shows 99% accuracy in current practice (100 consecutive cases audited dating backwards from 1.12.16)

3.8 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by MKUH in 2016/17, who were recruited to participate in National Institute of Health Research (NIHR) studies approved by a research ethics committee, was 3,187, with more data still to be included for this years' recruitment.

For 2015/16 we were the top recruiting small acute trust in the country, topping the league table for division1 (cancer), division 3 (Children, genetics, haematology, reproductive health and childbirth and division 6 (which includes: anaesthesia/peri-operative medicine and pain management, critical care, injuries and emergencies, surgery, ENT, infectious diseases/microbiology, ophthalmology, respiratory disorders, gastroenterology, hepatology). Our next closest rival was Harrogate and District NHS Foundation Trust with 2187 recruits and our league also included two

other University Hospitals. This was a major achievement for our research and development department and the Trust. This year 53 studies have contributed to the recruitment figures and we are currently in second position behind Homerton University Hospital NHS Foundation Trust.

The Research and Development department had a budget of £655,000 for 2016/17, 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 £700,000 for 2017/18.

Our aim is to provide patients with the latest medical treatments and devices and offer them additional treatment choices.

3.9 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 taken opportunities to inform the people of Milton Keynes of the research that is taking place at their local hospital. For example, the research and development team ran a stand at the MK play day to raise awareness of research taking place in paediatrics, and this was well attended by the local community. We also held a stand for Healthwatch to tell people about the variety of studies on offer for the local population, and in outpatients and the education centre for both patients and staff as part of International Clinical Trials Day. This was supported by the 'OK to ask' campaign, which aimed to increase awareness of trials in the general public.

A second grant submission has been made in relation to the Trust's 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, a Consultant General Surgeon, as chief investigator. MKUH would act as a sponsor for this clinical trial.

The research and development team supported the SNAP 2 study **(**The Sprint National Anaesthesia Projects: SNAPs) a 'snapshot' evaluation study of clinical activity and patient-centred outcomes that are important and relevant to both patients and anaesthetists.

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 MKUH.

The team have submitted expressions of interest for several commercial studies during this financial year, and have been awarded commercial studies in cancer, cardiology, diabetes and stroke. This will contribute to increases in the quality and

quantity of research opportunities offered to the Trust's patients and the public, and ultimately lead to better clinical outcomes.

3.10 Goals agreed with Commissioners CQUIN

A proportion of Milton Keynes University Hospital NHS Foundation Trust income in 2015/16 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 2016/17 are listed below.

National Goals

2016/17 CQUINs for Milton Keynes University Hospital NHS Foundation Trust			
Goal	**Goal Name**	**High level detail**	**Performance 2016/17**
1	Introduction of health and wellbeing initiatives-	The introduction of health and wellbeing initiatives for staff covering physical activity, mental health and improving access to physiotherapy for people with MSK issues.	This CQUIN has been achieved in full. **TBC.**
2	Healthy food for NHS staff, visitors and patients	Implementation of healthy food initiatives, including; the banning of price promotions and advertisements on sugary drinks and food high in fat, sugar and salt, the removal of these products from checkouts and ensuring healthy options are available to staff during night shifts.	This CQUIN has been achieved in full. **TBC.**
3	Improving the uptake of flu vaccinations for frontline clinical staff	Achieving an uptake of flu vaccinations by frontline clinical staff of 75%.	This CQUIN has been achieved in full. The Trust achieved a total frontline flu vaccination uptake of 78.6%.

4	Timely identification and treatment for sepsis in emergency departments	Improving the identification of patients with sepsis in emergency departments, and the timely initiation of treatment (IV antibiotics) within 1 hour alongside antibiotic review within 72 hours.	The Trust delivered 38% of the CQUIN screening element and 33% of the Treatment element. **TBC.**
5	Timely identification and treatment for sepsis in acute inpatient settings	Improving the identification of patients with sepsis in acute inpatient areas, and the timely initiation of treatment (IV antibiotics) within 1 hour alongside antibiotic review within 72 hours.	The Trust delivered 28% of the CQUIN screening element and 25% of the Treatment element. **TBC.**
6	Reduction in antibiotic consumption per 1,000 admissions	To reduce total antibiotic consumption, per 1000 admissions as well as to obtain evidence of antibiotic review within 72 hours of commencing an antibiotic prescription.	The Trust delivered 25% of this CQUIN. **TBC.**
7	Empiric review of antibiotic prescriptions	To improve the number of antibiotic prescriptions reviewed within 72 hours.	This CQUIN has been achieved in full. **TBC.**
8	Root-cause analysis on all long waiters and a clinical harm review for a positive diagnosis	To demonstrate appropriate management and review of long wait cases on the 62-day urgent GP referral to first treatment pathway, in line with the NHS England backstop policy.	This CQUIN has been achieved in full. **TBC.**
9	Therapy assessment within 24 hours of DTA	To perform comprehensive physiotherapy or occupational therapy assessment on patients over the age of 75, within 24 hours of admission with an EDD of greater than 3 days.	The Trust delivered 90% of this CQUIN.

Local Goals

Goal	Goal Name	High level detail	Performance 2016/17
1	Increased rates of breastfeeding	To educate and provide support to new mothers wishing to breastfeed their babies. The number of mothers having initiated breastfeeding within the first 48 hours of birth, to exceed 76% per month.	The Trust achieved 89% of this CQUIN.
2	Increased rates of breastfeeding (Community Midwife)	To educate and provide support to new mothers wishing to breastfeed their babies at discharge from Community Midwife. The number of mother's breastfeeding at discharge from Community Midwife to exceed 55% by March 2017.	The Trust did not deliver this CQUIN.
3	Discharges Before Midday	To support safe and effective discharge of medical patients admitted as emergencies: patients to be discharged safely before 12 (excluding patients with a zero length of stay)	The Trust achieved 18% of this CQUIN. **TBC.**
4	Prescription Chart to Pharmacy by 10am	All Medical patients to have their 'To Take Out' medication (TTO's) transcribed and sent to Pharmacy for checking and dispensing by 10am on the day of discharge.	The Trust achieved 68% of this CQUIN. **TBC.**
5	Improving Knowledge, culture and understanding of Mental health conditions in acute care	To improve knowledge of mental health conditions in acute care services, through providing support learning via quarterly learning events across a range of staff groups.	This CQUIN has been achieved in full. **TBC**.

Specialised Goals

Goal	Goal Name	High level detail	Performance 2016/17
1	Two year	To establish a robust system to recall,	This CQUIN has been

	follow up assessment for very preterm babies	evaluate and record outcome for babies born more than 10 weeks early and to ensure data is entered to the national BadgerNet system.	achieved in full. **TBC.**
2	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. **TBC.**

3.11 Care Quality Commission (CQC) registration and compliance

Milton Keynes University Hospital NHS Foundation Trust is required to register with the Care Quality Commission and it is currently 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.

Review of Compliance of Essential Standards of Quality and Safety
The Trust underwent an unannounced focused CQC inspection on 12, 13 and 17 July 2017 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.

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

Key findings from the report

- All staff were passionate 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 9 Hospital standardised mortality (ratio) was significantly better than the expected rate.
- Improvements had been made in the completion and review of patients “do not attempt cardio pulmonary resuscitation” 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 managers
- Local ward leadership was effective and ward leaders were visible and respected.

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.

Areas of Compliance or enforcements
The Trust received no notifications of compliance or enforcements actions as a result of this report.

Areas for Improvement identified by the inspection and how we have improved these since inspection

- 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 improved security at the paediatric emergency department.
- Staff, patients and visitors did not appear to observe the handwashing protocols in the emergency department – We have introduced more regular audits of the handwashing protocols in the department.
- The non-invasive ventilation policy was out of date - This has been re written and approved.
- The Medical Care Service did not have a policy for dealing worth outlying patients - This has been updated due to recent ward reconfigurations.
- 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. – The Trust has 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 have completed the required level of safeguarding children's training. - compliance is now over 90%
- There was poor compliance with assessing the risk of venous thromboembolism in the maternity service. A new process is now in place.

3.12 Data Quality

Milton Keynes University Hospital has data quality procedures in place to ensure data and information is accurately reported to support informed decision making. These data quality procedures range from ensuring data is input to transactional systems correctly and information is extracted and interpreted accurately and reported in a way that is meaningful and precise. All staff members who have responsibility for the input of data are trained fully in the use of the relevant systems.

Furthermore, 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.

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 2016/17 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	99.5 (99.3)	99.8 (99.5)	98.1 (96.8)
Completeness ethnicity	99.3 (96.6)	98.9 (94.4)	98.4 (95.5)

*Figures from the SUS data quality dashboard M11 – national average in brackets.

The Trust recognises the importance of data quality and has established a Data Quality Compliance Board (DQCB). The DQCB was not setup as a traditional governance committee, but more akin to a committee with a “regulatory focus”, where the focus was to ensure compliance is achieved through regulatory action. On the establishment of the DQCB, a number of actions were immediately delegated to appropriate departments to implement, allowing the committee itself to provide the level of assurance against these actions as appropriate. One of the key actions related to the production of a data quality policy which was line with our peer Trusts to ensure we at least maintained a consistent level of expectation to other Trusts. Another key action involved the production of a data quality dashboard. The over-arching vision is to get all teams to work together for better and improved data quality.

3.13 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.

3.14 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**
Summary Hospital-level Mortality Indicator (SHMI)	**MKUHFT**	1.04 (Band 2)	0.95 (Band 2)	1.04 (Band 2)	1.04 (Band 2)
	National	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 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.

Milton Keynes University Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality. Banding 2 means that the mortality rate is 'as expected'.

There is an increasing level of scrutiny of mortality information across services provided by the trust and in depth analysis where mortality levels are outside the normal range. We are also now reviewing all unexpected deaths using the new national protocols.

Our priorities this year continue to focus on improving this result as they include management of sepsis and the early recognition of the deteriorating patient.

(The Trust is no longer required to report against indicators 2 and 3)

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

What are PROMS (Patient Reported Outcome Measures)?

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 to measure and improve 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: by improving the response rate of post-operative questionnaires and reviewing the newly released data when available. The latest data for 2016/17 was released in February 2017 and relates to the period of April 2016 to September 2016 only. Currently there is insufficient data to present a representation of the Trust.

Full provisional data is available for April 2015 to March 2016 (data published Feb 2017) this shows there were 648 eligible hospital episodes and 644 pre-operative questionnaires returned a participation rate of 99.4% (74.9% in England). Of the 637 post-operative questionnaires sent out, 392 were returned a response rate of 61.5% (69.8% in England)

EQ-%D Index results

Patient reported outcome measure for	Level	2014/15	Provisional results 2015/16	Provisional Apr- Sep 2016
Groin Hernia Surgery	MKUHFT	82.3%	88.8%	Insufficient data
	National	87.7%	87.8%	88.0%
Varicose veins surgery	MKUHFT	Insufficient data	Insufficient data	Insufficient data
	National	84.1%	83.7%	84.2%
Hip Replacement surgery	MKUHFT	78.0%	83.1%	Insufficient data
	National	79.7%	80.0%	81.1%
Knee replacement surgery	MKUHFT	81.0%	74.6%	75.5%
	National	0.7%	74.3%	Insufficient data

As can be seen in the table above, there was a slightly greater average health gain reported following hip surgery on the Eq-5D Index than the national figure. (Scores on the EQ-5DTM Index range from -0.594 (worst possible health) to 1.0 (full health))

Figure 1: Adjusted average health gain on the EQ-5D™ Index by procedure

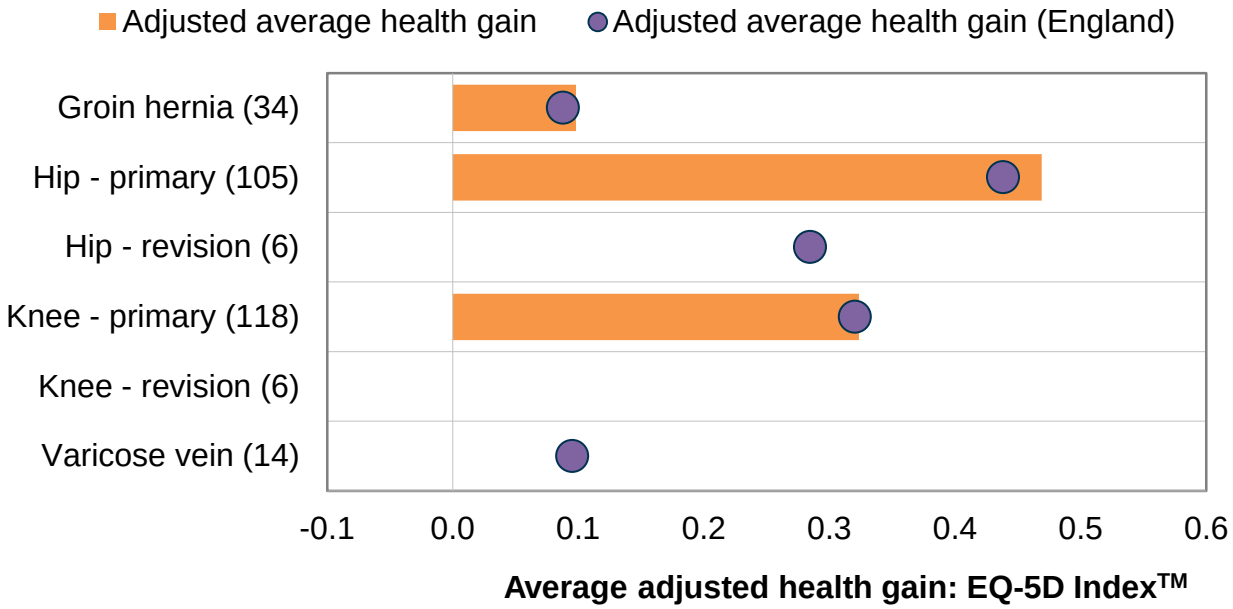
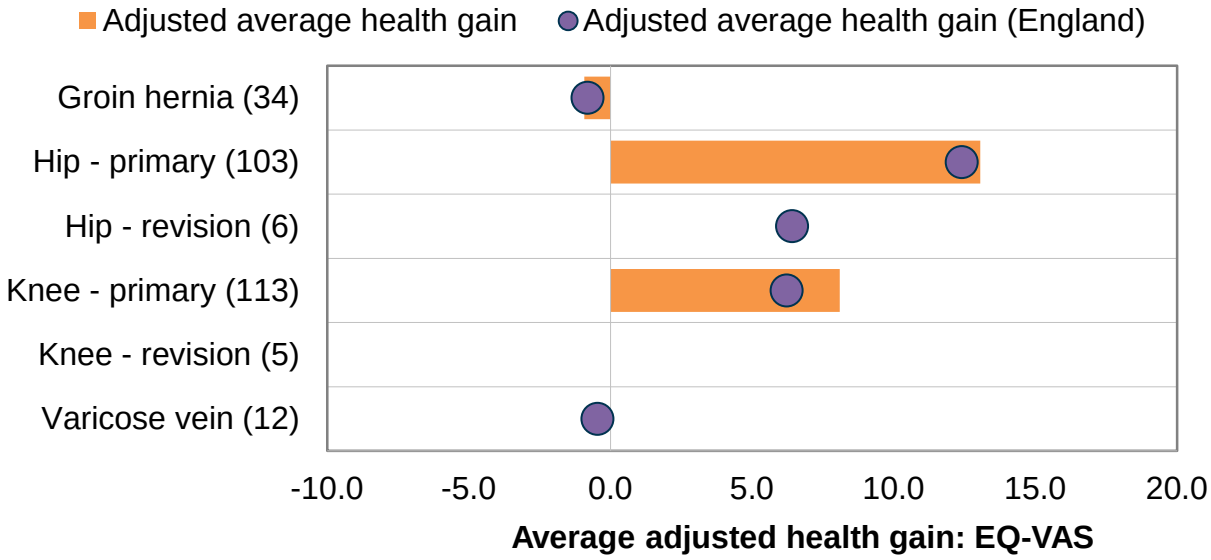


Figure 2 identifies slightly better than national average health gain following knee surgery and hip surgery using the EQ-VAS tool. (Scores on the EQ-VAS range from 0 (worst) to 100 (best))

Figure 2: Adjusted average health gain on the EQ-VAS by procedure



The other surgeries did not highlight a significant difference from the national average or insufficient numbers of patients either received the treatment or participated in the questionnaires.

3.16 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**
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)

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.

Milton Keynes University Hospital NHS Foundation Trust has taken action to improve this rate, and so the quality of its services: by continuing to review why patients are readmitted. We have developed new discharge pathways with our colleagues in the community health services and local social care teams which allow patients to be discharged earlier and also receive greater support at home to prevent re-admission. This project is called “discharge to assess” and early evidence suggests patients are staying at home for longer periods. We are also implementing the SAFER bundle as described in our quality priorities

3.17 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**
Responsiveness to the personal needs of patients	**MKUHFT**	65.3%	68.9%	68.0%	Next update August 2017
	National	68.7%	68.9%	69.6%	
	Other Trusts Low/High	*54.4%/84.2%*	59.1/86.1%	58.9%/86.2%	

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.

In 2015/16, the Trust established a new patient experience team, and that team is continuing to work with the clinical teams to improve patients' experience of receiving care. That team includes a medical lead and a full time patient experience manager. The team have been working on how best to use the valuable information that the public give us about our services. Our priorities are:

- Improving food selection for patients;
- Wayfinding around the hospital in light of development of the site; and
- Improving booking and communication of hospital appointments and elective surgery.
- Reducing noise at night

3.18 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**
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.

Milton Keynes University Hospital NHS Foundation Trust has taken action to improve this rate, and so the quality of its services by, continuing to ensure that staff feel supported and their feedback is heard and responded to. Staff have a number of ways of giving feedback, face to face and anonymously. Weekly messages from the Chief Executive also include individual accolades received and achievements by teams. We have seen a year on year improvement in this score which we believe represents the general improvements the Trust has made in care and engagement of staff in this process.

3.19 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.

Milton Keynes University Hospital NHS Foundation Trust has not met this target this year due to administration issues which have been resolved. The Trust continues to check the robustness of its process to ensure continued delivery.

3.20 Indicator 12: Rate of C difficile

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 has seen a continuous reduction in the number of C-difficile cases this year. We have achieved this by strict infection control processes and by restricting the use of anti-biotics linked to C-difficile. This year we will continue to extend this successful programme.

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

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**
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%
	National	96.0%	96.1%	95.6%	95.8%
	Other Trusts Low/High	80%/100%	90%/100%	79%/100%	80%/100%
24. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2015/16**
Rate of C.difficile infection (per 100,000 bed days)	**MKUHFT**	22.5	23.4	10.5	*Next update due July 2017*
	National	14.7	15.0	14.9	
	Other Trusts Low/High	0/37.1	0/62.6	0/66.0	
25. Domain of Quality	**Level**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
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)	
	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)		

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 is taking action to improve this rate, and so the quality of its services, by continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality as we are below the national average for this indicator.

Part 4 Other Information

4.1 Review of Quality 2016/2017

PATIENT SAFETY				
Indicator	**Measurement used**	**2014/15**	**2015/16**	**2016/17**
Hand hygiene compliance	Internal target – percentage compliance as measured by exception	87.95%	91.1%	(TBC)
Hospital-acquired pressure ulcers (Grades 3 and 4)	Internal target – total number recorded on Datix and investigated through Serious Incident framework (electronic incident reporting system)	23 gd 3 1 gd 4 5 gd 3 (downgraded)	9 grade 3 1 grade 4 (3 gd 3 downgraded, 1 gd 4 downgraded)	15 (grades to be confirmed)
Patient falls	Internal target – total number of reported incidents	776	12 moderate harm (change in reporting)	17
Medication incidents	Internal target – total number of reported incidents	713		105
Serious incidents	Internal target – total number of reported incidents	125	91	74
"Never events	This is based on a nationally accepted list of events published by the National Patient Safety Agency	1	3	2

4.2 Hand hygiene compliance

Ensuring that all hospital staff clean their hands between patients has contributed towards a reduction in health care associated infections across the NHS.

The data collection tool reflects the World Health Organisation's five moments of hand hygiene and bare below the elbow standard. The 38 areas complete the audit and this is reported on a monthly basis. Those areas that have a lapse in compliance or fail to return the audit are written to by the Chief Nurse. The Infection Prevention Control Team and clinical teams continue to promote the effective hand hygiene and bare below the elbow standards.

4.3 Hospital Acquired pressure ulcers (grade 3 and 4)

There continues to be improvement in the identification of patients with pressure ulcers and those at risk of developing of pressure ulcers at admission with the appropriate actions being implemented in a timely manner to reduce the risk of further skin damage. As can be seen by the overall reduction in the number of grade 3 and 4 pressure ulcers developed over the past year. All hospital acquired grade 3 and 4 pressure ulcers are reported as a potential Serious Incident and require a 72 hour report to be completed. On receipt of this report a decision is made about whether the pressure ulcer reported could have been prevented or whether all preventative care had been provided and therefore the ulcer was unavoidable.

All grade 3 and 4 pressure ulcers are reported through the safeguarding process as a potential safeguarding concern regardless of the decision about it being avoidable or unavoidable or a SI being declared.

The root cause analysis of the pressure ulcers is monitored from divisional level through to management board. Pressure ulcer prevention has been a quality priority for 2016/2017 and will continue to be a key indicator of quality and ongoing improvement action for the year ahead.

4.4 Patient Falls

As suggested in last year's Quality Account, measuring the level of harm that a fall causes is a better indicator of how we have improved through falls prevention. Low or 'no harm' indicates effective falls prevention as not all falls can be prevented but the impact can be reduced.

As the number of patients attending the hospital increases it is probable that the number of falls will increase. Comparing the number of falls with the number of occupied bed days makes it possible to assess whether the rate of falls is changing. A rate of 4.7 falls per 1000 bed days was reported in February 2017 (compared to 4.02 in February 2016. It is noted that an increased number of patients were admitted after a fall, which increases the likelihood that they may fall again.

Falls prevention training and education continues to be provided and for all registered nurses and Health Care Assistants as part of the essential skills

programme. The Post Falls protocol which initiates a whole team approach to reviewing why a patient has fallen and to reduce the risk and harm if they are to fall again has been successfully embedded with all relevant members of the multi professional team completing their relevant areas.

4.5 Medication Incidents

Medication incidents are reported onto our incident reporting system when errors have been made. An error is reported even if no harm has been caused to a patient. Errors can be about prescribing, dispensing (when the pharmacy department issues medications) or administering (when medication is given to the patient). Reporting medication incidents is the right thing to do and investigations into incidents often provide all staff with learning and sharing of improvements in practice.

4.6 Never Events

NHS Improvement describes Never Events as “serious, largely preventable patent safety incidents that should not occur if existing national guidance or safety recommendations have been implemented by healthcare providers”. There are 20 listed categories of Never Events, and a total of 380 Never Events were recorded nationally in 2016/17. This Trust reported two Never Events during this timeframe.

NHS England Never Event 10 – A patient falling from a poorly restricted window:

At approximately 22.30hrs on 8th December 2016 there was a Code Victor call to Ward 8 where a 52 year old male patient had managed to fully open the right sided window in bay 4, stand on a footstool and exited, falling and suffering a significant compound fracture to his left lower leg and a fracture to his right lower leg.

Although the Trust did not initially declare this as a never event since the patient had disclosed during his recovery post fall that he “fiddled with the window” which could be interpreted as he “disabled the restrictors” to enable to window to be opened prior, this decision after further analysis was amended in March 2017.

Following this incident and the subsequent investigation all window restrictors have been replaced and there is an ongoing scheduled maintenance programme with Estates, with each window being specifically numbered and easily identified on a site plan. The checking of window restrictors has also been added to the departmental quarterly health and safety checklist compliance from which be monitored by the Health and Safety Committee.

NHS England Never Event 1 – Wrong site surgery:

A patient was scheduled and consented for left ureteric stent insertion. During the World Health Organisation (WHO) sign out it was noted that stent had been inserted in to the right ureter instead of the left (as per consent form). The patient was still anaesthetised, and instrument trays were still sterile. The Consultant Urologist was

contacted, who attended theatre, the incorrectly placed stent was removed and a stent was inserted to the left ureter.

The incident remains under investigation, but early analysis indicates that it was caused by human error, and that there was full compliance with Trust processes and procedures at the time.

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.

The Trust held a 'learning from serious incidents' plenary session on the audit afternoon of the 22nd November 2016, with presentations and group discussions on the key learning to ensure cross specialty learning and to embrace the Trust's open and honest approach to learning from incidents.

The Trust's Datix system allows feedback to staff reporting incidents on an individual basis. All specialty governance group meetings further include learning from incidents/serious incidents at their meetings, with newsletters also circulated to ensure as wide an audience is included.

Following some serious incident investigations the Trust has arranged subsequent simulation training for staff with similar scenarios to facilitate practical and skills based learning for teams, with a view to expanding this more in 2017 – 2018.

Mock Inquest

A mock inquest was held on the 20th October 2016 which involved the Trust's legal team, Trust staff and HM Coroner to allow staff to appreciate how an inquest is run and to identify the key requirements for giving evidence and providing statements. This was recorded so it can be used subsequently as a teaching aid across the organisation.

4.7 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.

4.8 Sign up to Safety Campaign

The Trust signed up to the Sign up to Safety Campaign in September 2014 in the five areas below:

Reducing avoidable harm by referencing it's priorities for 2015/2016 of:

1. Reducing the number of deaths from sepsis
2. Reducing the number of inpatient falls by 5%
3. Eliminating hospital acquired grade 3 and pressure ulcers
4. Ensuring that patients admitted emergencies are reviewed by a consultant within 48hrs
5. Increasing medication error reporting by 20%

These were seen to be replicable to the incident and serious incident trends noted in the Trust at the time, and in line with ongoing work streams to ensure safe and effective patient care. Monitoring of the campaign and progress with the work streams projects is managed through the Serious Incident Review Group (SIRG).

4. 9 Clinical Effectiveness

CLINICAL EFFECTIVENESS					
Indicator	**Measurement used**	**2013-14**	**2014-15**	**2015-16**	**2016-17**
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
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
Still birth rate	Per 1,000 deliveries	5.7	2.1	3.2	3.4
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%

4.10 Patient Experience

PATIENT EXPERIENCE				
Indicator	**Measurement used**	**2014-15**	**2015-16**	**2016-17**
Complaints	**The number of complaints from patients received by the Trust**	**609**	**897***	**838**
Midwife : birth ratio	Birth Rate Plus Midwifery Workforce planning tool	1 to 30	1 to 32	1:31

In 2016/17 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 24000 Friends and Family Test (FFT) responses a month, from over 65 wards and departments 'collection points'. The averages recommend rate for the Trust is 93%. The FFT responses can now be fed back using SMS text messaging in Emergency Department (ED). The new supplier for FFT can also support responses by website link and a QR code link for smart phones as well as the standard 'paper survey'. This additional methodology to feedback on care has created a shift to electronic feedback in the ED department. We believe this will increase the FFT response rate. FFT 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 Patient Opinion) are being shared as quickly as possible to department heads and clinician's. This prompt feedback can mean that appropriate actions can immediately in response to concerns raised. In addition to feedback received from patients and families/ carers there is a regular programme of '15 Step Challenge' visits to wards and departments, where feedback is shared promptly to facilitate change and improvement in patient experience. The Patient Experience 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.

Performance against key national priorities and regulatory requirements 2010 to 2017				
Indicator	**Target and source (internal /regulatory /other)**	**2014-15**	**2015-16**	**2016-17**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	>96% set by NHSI	98%	99%	TBC
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	>85% set by NHSI	87%	84%	TBC
Maximum wait of 2 weeks from GP referral to date first seen for all cancers	>93% set by NHSI	95%	95%	TBC
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments	>98% set by NHSI	100%	100%	TBC
Maximum waiting time of 31 days for subsequent cancer treatments: surgery	>94% set by NHSI	100%	98%	TBC
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients	>93%	96%	95%	TBC
Referral to treatment in 18 weeks - patients on incomplete pathways	Patient on an incomplete pathway: 92%	93%	86%	93%
Diagnostic wait under 6 weeks	>99%	99%	98%	100%
A&E treatment within 4 hours (including Walk-In Centre)	95% set by NHSI	92%	94%	92%
Cancelled operations: percentage readmitted within 28 days	>95%	99%	86%	87%
Clostridium difficile	Set by DH	39	29	10

infections in the Trust				
MRSA bacteraemia (in Trust)	Zero tolerance set by DH	0	2	2
MRSA bacteraemia (across Milton Keynes total health economy)		3		Awaiting data

ANNEX 1 – Statements from NHS: Milton Keynes and Milton Keynes Healthwatch

Statement from Milton Keynes Council Quality Account's Panel

Statement from Central Bedfordshire Council Health Overview and Scrutiny Committee

Trust Response

The Trust welcomed the constructive comments of Milton Keynes Council, Quality Account Panel on xxxx. A more detailed index has been included in the Quality Account and a glossary added to the document.

Statement from Milton Keynes Clinical Commissioning Group dated xx May 2017

MKCCG comments to MKUHFT Draft Quality Account 2016-17

Trust Response

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 2016/17;
- 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 2016 to May 2017
    - papers relating to quality reported to the Board over the period April 2016 to May 2017
    - Feedback from the commissioners dated
    - Feedback from governors on quality priorities dated 6 March 2017
    - Feedback from the local Healthwatch organisation dated
    - Feedback from Local Authority dated
    - 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 2017.
    - The national patient survey received April 2017
    - The national staff survey February 2017
    - The Head of Internal audit's annual opinion over the Trust's control environment dated April 2017
- 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 Monitor's annual reporting 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 (to be updated)

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 organisation
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
CIG	CIG	Clinical Improvement Group	
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 Agreement**	**an agreement between two or more 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**