Milton Keynes University Hospital NHS Foundation Trust 2021/22 Quality Account

Part 1: The Quality Account

1.1 Introduction

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

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

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

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

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

We are proud of our professional, compassionate staff and of our strong relationships with local stakeholders. The involvement of patients, the public, governors, Healthwatch Milton Keynes, and health and care system partners is integral to our development. Our governors are involved throughout the year in monitoring and scrutinising our performance. The governors continue to demonstrate their commitment to fulfilling their role as the elected representatives of patients and the public, through their direct contacts with members of the community, as well as their participation in a range of community forums, including Healthwatch Milton Keynes and various patient participation groups.

During the year, we have continued – as far as possible within the COVID-19 pandemic restrictions - to actively engage with the Milton Keynes Council Health and Adult Care Scrutiny Committee and the Health and Wellbeing Board on quality matters concerning the Trust as an acute hospital and those affecting the wider health and care system.

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

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

One of the requirements in compiling the Quality Account for the previous financial year (2021/22) is to select at least three quality priorities for the year ahead (2022/23). These priorities are included in Part 2 of the Quality Account.
In selecting quality priorities, the following criteria should be satisfied:

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

Once agreed the Quality Account must indicate how the priorities will be met, monitored, measured and reported by the Trust. The Quality Account provides an evaluation of progress in meeting the quality priorities set for 2021/22 and gives a general overview and evaluation of how well the Trust has performed across a range of quality metrics throughout the year.

1.2 Statement on Quality from the Chief Executive

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

The Quality Account provides us with a chance to look back on how we improved our quality of care provided to patients throughout 2021/22, and where there are opportunities to make further improvement moving into 2022/23 and beyond.

This Quality Account is different to that published in normal years because it continues to reflect some of the significant effects of the COVID-19 pandemic, which reached the UK in March 2020 and continued throughout 2021/22, presenting vast challenges to our staff and making a major impact on the delivery of our services. Our staff have worked incredibly hard to maintain services during this very difficult period for all, and it is clear that the effects of the pandemic will be felt by our Trust for some time to come.

Every year our Trust outlines its three objectives: improving patient safety, improving patient experience and improving clinical effectiveness. Our aim is for every patient to benefit from excellent care provided by our Trust, and we seek to deliver this excellent care by making these objectives the driving force behind everything we do as a hospital.

One of the success stories during 2021/22 was the Trust's continued use of technology to improve quality of care and patient safety. Our hospital is constantly seeking ways to embrace technology to enable our staff to work more efficiently and more effectively, and to help to provide services to patients in the way that they would like to receive them. These innovations have included the final implementation phase of the eCARE system (electronic patient records) in September 2021 in theatres, anaesthetics, paediatrics and the Intensive Care Unit, meaning the system was live all across the Trust. eCARE helps our staff to provide quicker, safer and improved treatment to our patients by enabling staff to easily obtain up-to-date information on patients' health by putting it all on one easy-to-access, secure and confidential place, thereby enabling staff to make the best decisions more quickly about patient care. The time saved by staff through the use of new technologies allows them to spend more time focusing on treating patients.

A further advance came in December 2021, when our Trust became the first in the country to integrate the new national NHS Learn from Patient Safety Events (LFPSE) service, having partnered with software specialists Radar Healthcare. The new service is improving the safety of our own patients here at MKUH, by improving how patient safety events are recorded, but also using insights combined with technology such as machine learning to help predict and reduce future incidents.

Our strides on digital improvements have been matched by our physical developments to the hospital site, with plans to further develop our estate continuing into 2021/22, in spite of the pandemic. We continued construction work on the new Maple Centre (formerly called the Pathway Unit) next to the Emergency Department, where the old Maple Unit was situated before it was demolished. We are hoping to open the new centre by the end of 2022, and this is tremendously exciting. With 26 beds and 16 assessment rooms, the Centre will help to ensure patients can receive the emergency care they need without becoming an inpatient at the hospital. The Milton Keynes population is one of the fastest growing in the UK, with half a million expected to be living in the town by 2050, so it is important that our hospital

continues to expand and improve its services, facilities and infrastructure in order to meet the demands that will come with that increased growth. Planning continues apace for the Trust's expansion, including a new Women's and Children's Hospital, surgical block and imaging centre in the coming years. These service improvements will help to further improve the quality of our treatment and care to patients, helping us to achieve our objectives in line with our responsibilities to the development of Milton Keynes as a town, and we will continue to work with our partners and engage with the public in order to deliver on these.

Throughout the pandemic we have had a policy of reduced footfall across the site to reduce transmission of COVID-19, and this has meant that we have continued to use technology to provide virtual appointments to patients. This not only saves vulnerable patients from having to make the trip to the hospital, but also reduces the numbers of cars on the road in Milton Keynes and frees up car parking spaces at the hospital. And our introduction of Patient-Initiated Follow-Up has put patients in control of making a follow-up appointment, providing them with direct access to guidance when they need it. patients can make their own appointment only when they need it: for example, when they experience a flare-up of their condition. This will reduce any unnecessary anxiety, travel, and time spent waiting for a routine follow-up, whilst also releasing clinical teams to see more patients in a timely manner.

In terms of performance, this year has been challenging in terms of maintaining services whilst providing care through the pandemic. The Trust's cancer performance has been challenging throughout the financial year due to a significant rise in cancer referrals and the Trust having to recover from the backlog that resulted from the pandemic. This is not dissimilar to the challenges faced by other Trusts. All our quality performance indicators are published at every Trust Board meeting in order that the public can view our performance against national, internal and peer-benchmarked metrics, with indicators including statistics for infection rates, pressure ulcers, serious incident figures and mortality measures.

Patient and family experience is always important to us, and the number of complaints received by the hospital increased from 829 in 2020/21 to 1042 in 2021/22. We continue to welcome and actively seek feedback from patients who receive treatment and care from us so that we can continue to find ways to further improve the quality of care that we provide.

There is no doubt that 2021/22 was a very challenging year for all, but we move into 2022/23 with positivity.

1.3 Statement of Assurance

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

- Data are derived from a large number of different systems and processes. Only some of these are subject to external assurance or included in the internal audit programme of work each year.
- Data are 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 reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

During the year – as far as possible within COVID-19 pandemic restrictions - 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.

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.

Professor Joseph Harrison
Chief Executive

20 June 2022

Part 2: Priorities for Improvement and Statement of Assurance from the Board

2.1 Priorities for Improvement in 2022/23

This section of the Quality Account describes the areas we have identified for improvement in 2022/23. In March 2022, these priorities were shared with and agreed by our Quality and Clinical Risk Committee and Council of Governors – a body made up of elected members of staff, members of the public and nominated stakeholder representatives.

The plan is to realign the 2021/22 priorities, continuing aspects of some for a third year as they, particularly priorities two and three, align with the Trust's operational priorities and wider national ambitions, and to select a safety priority based on current safety data.

It should be noted that the priorities for 2021/22 were continued from 2020/21 because the delivery of the 2020/21 priorities were significantly impacted by the operational challenges of the Trust's response to COVID-19. The Trust had deemed it appropriate to continue with 2020/21 priorities 2021/22, refreshing the metrics and objectives, and considering ongoing COVID-19 priorities.

The first priority, reducing deep tissue injuries – also called pressure ulcers - is an area that has the potential to provide significant improvements in patient safety.

The second priority, reducing long waiting times in elective care, will improve patient safety, experience and the effectiveness of their treatment.

The third priority, reducing discharge delays, will improve patient experience and ensure the health and care system overall is caring for people in the right place at the right time.

Priority 1: Reduction in deep tissue injuries (pressure ulcers)

- **Why have we selected this priority?**

Pressure Ulcers have a significant impact on patient outcomes and wellbeing and therefore is one of our key quality priorities. Deep tissue injury is damage to the skin where the depth is unknown, the blood flow to the area is diminished and therefore is likely to be deep damage occurred.

- **What is our past performance in this area?**

In 2021/2022 a 19% reduction was seen overall in the number of reported DTI's (43 reported in comparison 53 reported in 2020/21).

Although an overall reduction in year for reported DTIs there was a reported increase in reporting during quarter 3 and 4 which is a concern requiring further analysis.

The main location of prevalence was recorded as:
· Heels 41%

· Sacrum 19%

In Medicine there were 30 reported DTIs for the year and in Surgery there were 13 reported DTI's. The areas with highest recorded DTIs are Wards 1 and Ward 23. Both areas are completing a Thematic review with the input of the safety leads for the Trust using an AI approach to identify learning which will inform a robust action plan.

- **How will we monitor and measure our performance in 2022/23?**

All pressure ulcers, moisture lesions and patient falls are reported via the new Trust reporting system RADAR. From April to December 2021 this was via our Trust DATIX system. RADAR was implemented on the 15th of November 2021 and therefore there has been a period of data transition which has had an impact on data availability and analysis. Previous data was captured on DATIX in accordance with NHS England parameters. The new RADAR system captures a different set of data in accordance with NHS Improvement – the Trust is the first to change these parameters and will benchmark these nationally for categorising data for falls and pressure ulcers.

For all pressure damage validated as category 2 and above and falls where a moderate level of harm is sustained a summit is undertaken, involving members of multi-disciplinary teams to encourage critical reflection, development of ideas, identify themes and any learning which are then recorded in an approved action plan.

Assurance is obtained through robust governance process including incident presentation at the Trusts Serious Incident Reporting Group (SIRG) with agreed action plans being monitored by the Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group (BLMK CCG).

Monitoring will also be driven through divisions with Divisional Chief Nurses and Matrons undertaking daily senior nurse ward rounds and monthly quality reviews. Reviews will be informed using data reported on RADAR and Tenable audit data regarding assessment compliance.

Monthly Nursing quality indicator data will be used to inform the focus of senior nursing weekly corporate rounds, which are undertaken to provide triangulation of indicator performance and quality assurance, enable opportunity of a senior deep dive into areas of concern and share learning of practice.

Monthly divisional and organisational pressure ulcer performance data will be recorded and tracked via Trust quality performance scorecard.

A draft sitrep proforma for pressure ulcers is being developed and will be piloted within the corporate nursing team over Q2 2022/2023

- **How will we report our progress against achieving this priority**

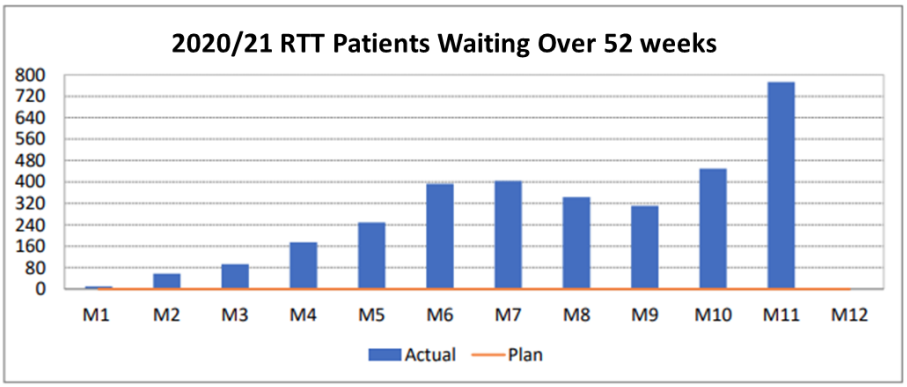
Progress will be reported via Patient Safety Board, the Trust Board of Directors' Quality and Clinical Risk Committee and on the Trust Quality performance scorecard.

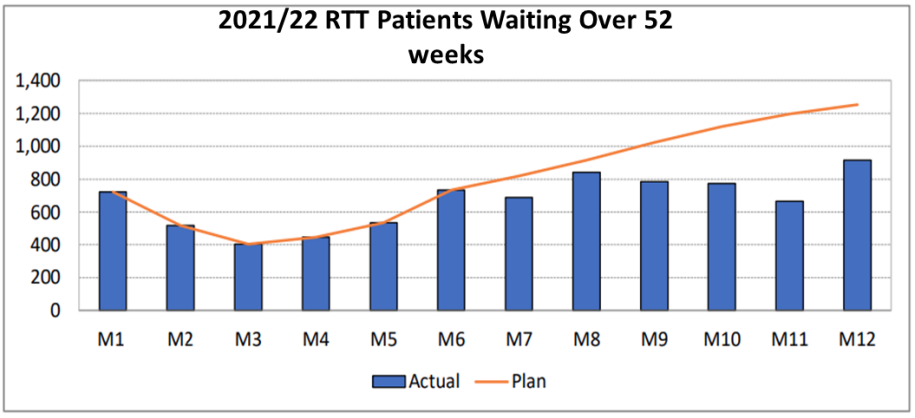
Divisional progress will be reported and discussed through internal clinical improvement groups and monthly divisional management board.

Priority 2: Improvements in (elective care) to reduce long waiting times

- **Why have we selected this as a priority?**
  There has been a marked increase in elective waiting times since the start of the pandemic with much elective activity stood down during COVID-19 waves and patients delaying accessing their GP for referral into secondary care services. Reducing elective waiting times to pre-pandemic levels is a national priority, as well as a key priority for MKUH.

- **What is our past performance in this area?**
  The charts below taken from Board Performance Reports show MKUH performance in elective patients waiting over 52 weeks through 2020/21 and 2021/22.





- **How will we monitor and measure our performance in 2022/23?**
  Performance in elective waiting times in 2022/23 will continue to be monitored through the monthly Board Performance Report, a key measure of elective waiting times is patients waiting over 52 weeks. Each division and specialty will also continue to monitor and review patients waiting over 52 weeks.

  Additionally, MKUH have set a suite of Quality Operational Priorities which includes a maximum wait time of 40 weeks for outpatient RTT patients.

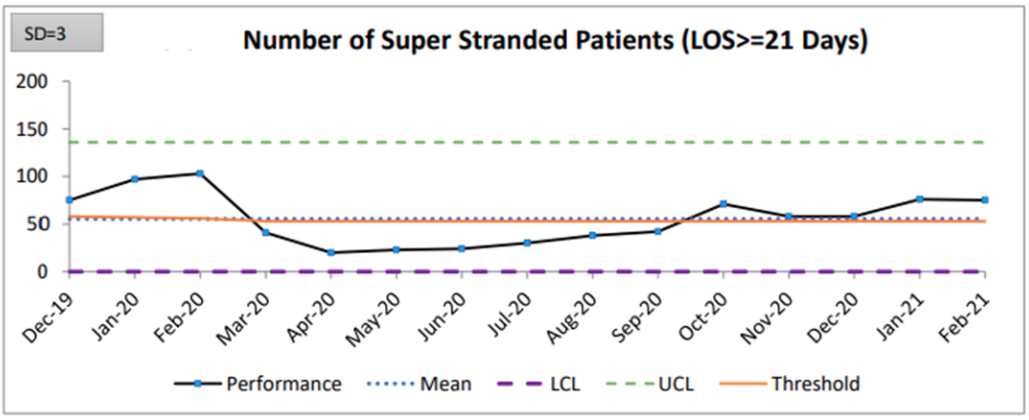
- **How will we report our progress against achieving this priority?**
  Progress will be reported through the monthly Trust Board Performance Report, it will also form part of Trust national returns.

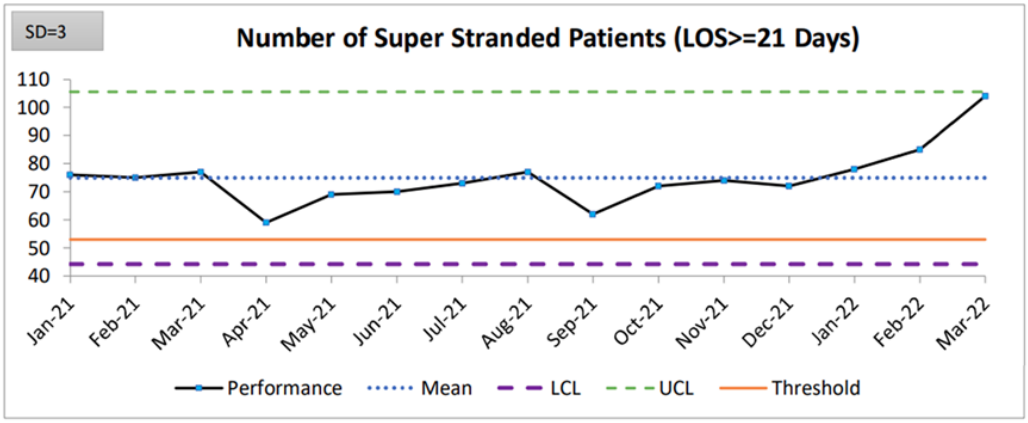
Priority 3: Reductions in discharge delays

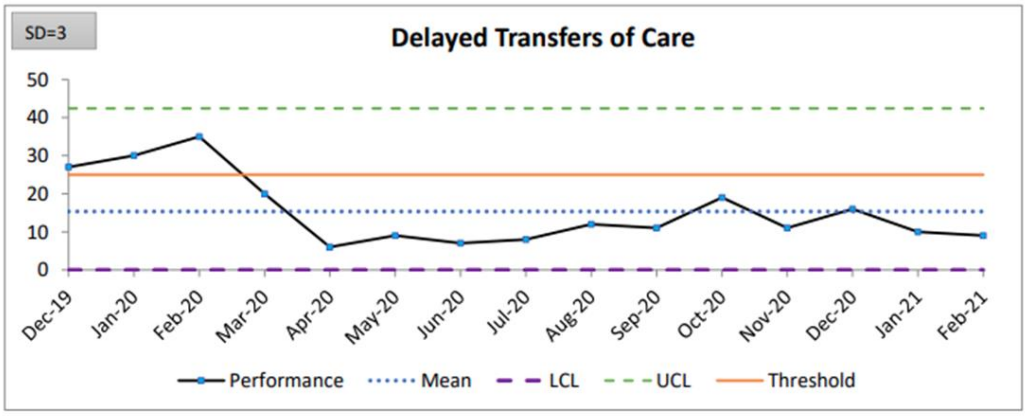
- **Why have we selected this as a priority?**
  The number of patients we see in MKUH with a delayed discharge has increased since the start of the pandemic and is evidenced across a range of metrics. Reducing delayed discharges or reducing the number of patients who do not meet the criteria to reside in an acute hospital, is a national priority and key area of focus for MKUH.

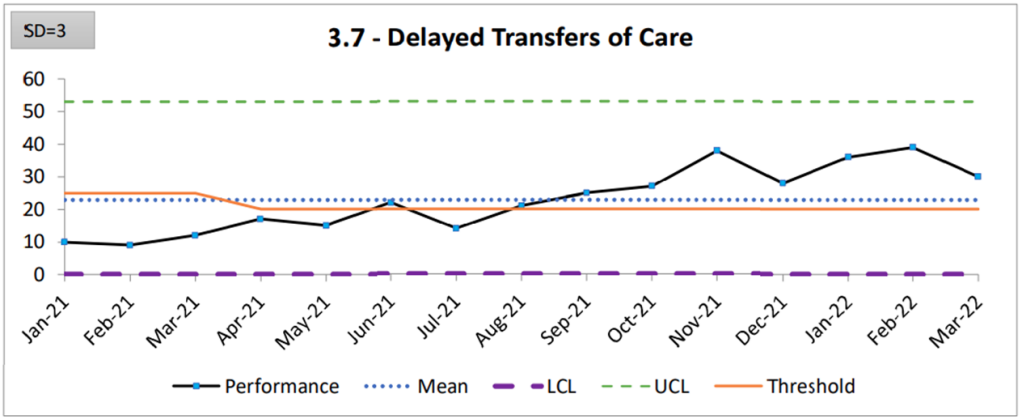
  Delayed discharges are where patients remain in hospital when no longer clinically required meaning that they are not in the most appropriate setting for their needs, whether that is at home, with or without additional support, in a care home, nursing home or other facility. They directly impact the bed availability for patients who do need acute care, contributing to ambulance handover delays, delayed admissions to a ward setting, the opening of escalation bed capacity and a dilution of hospital staff numbers to provide the care required.

- **What is our past performance in this area?**
  The graphs below show the number of super stranded patients (with a length of stay >+21 days) and the number of delayed transfers of care through 2020/21 and 2021/22.









- **How will we monitor and measure our performance in 2022/23?**
  Performance in delayed discharges in 2022/23 will continue to be monitored through the monthly Board Performance Report, key measures are super stranded patients and delayed transfers of care.

- **How will we report our progress against achieving this priority?**
  Progress will be reported through the monthly Trust Board Performance Report, it will also form part of Trust national returns.

2.2 Our Performance against Priorities for Improvement in 2021/22

Priorities for 2021/22:

1. Improving Care for Inpatients with Diabetes
2. Improvements in Outpatients Efficiency
3. We will reduce length of stay for our older patients

Due to the continuing significant impact on operations by the COVID-19 pandemic in 2021/22, the 2021/22 Priorities were not progressed.

2.3 Statement of Assurance from the Board of Directors

During 2021/22 Milton Keynes University Hospital NHS Foundation Trust provided and/or sub-contracted 36 relevant health services.

Milton Keynes University Hospital NHS Foundation Trust has reviewed all data available to them on the quality of care in 36 of these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health services by Milton Keynes University Hospital NHS Foundation Trust for 2021/22.

2.3.1 Clinical Coding Audit

During 2021/22, Milton Keynes University Hospital was not subject to the Payment by Results clinical coding audit.

2.3.2 Submission of records to the Secondary Users Service

Milton Keynes University NHS Foundation Trust submitted records during 2021/22 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

2.3.3 Information Governance Assessment Report

The Trust completed and published its Data Security and Protection Toolkit assessment for 2020/21 on 10/08/2021, having achieved ‘Standards Met.’

2.4 Participation in Clinical Audits

Participation in Clinical Audit and Clinical Outcome Review Clinical Audit is a quality improvement process that is defined in full in “Principles for Best Practice in Clinical Audit” (Healthcare Quality Improvement Partnership 2016). The programme allows clinicians and organisations to assess practice against evidence and to identify opportunities for improvement. Milton Keynes University Hospital NHS Trust is committed to undertaking effective clinical audit and quality improvement within all clinical services to inform the development and maintenance of high-quality patient-centred services

During the COVID-19 pandemic, many of the National Clinical Audit programmes were suspended. The team at Milton Keynes University Hospital used this hiatus to review the audit database and make improvements relating to ease of use and the reporting methodology. This revised database allows users to access the clinical audit data and updates more easily.

For 2021/22, Milton Keynes University Hospital fully participated in the National clinical audits programmes.

There is evidence of good practice, learning and action planning from the National Clinical audit programme across the organisation. Performance and support for both NCA participation and implementation of service development is offered via the Clinical Audit & Effectiveness Board and the Clinical Service Units. An example of learning from the data is an intervention to reduce outlier infection rates shown by the NJR data. Since identifying a high infection rate in the 2018-19 NJR data, the Orthopaedic team introduced numerous evidence-based changes to the departmental practice that have reduced our infection rate to 0.5% annually (which is now below the national average of 1%).

The National Paediatric Diabetes Audit demonstrated the team’s high performance with 89.8% of patients receiving all key care processes annually.

As well as participation in the national clinical audit programme, the staff designed and undertook other relevant local audits and benchmarking. The Pathology areas provides assurance around all MHRA compliance requirements, HTA compliance requirements and UKAS requirements. MK Pathology has been successfully re-assessed against ISO 15189 by UKAS, which includes accreditation for Serology and Haematology. The Imaging department undertook 80 audits of service provision in 2021. An audit of compliance with the CT head angiogram stroke protocol demonstrated excellent results with time ranges from 0-18 mins from time of request to attendance on CRIS. The average time of 7 mins has improved from 10 mins in 2019 and 33% patients were scanned within 2 mins of request. 48% in 5 minutes. 70% within 10mins. It is clear from the data that the excellent communication between the CT team and the stroke team enables scans to be performed swiftly and efficiently from the time of request to the scan.

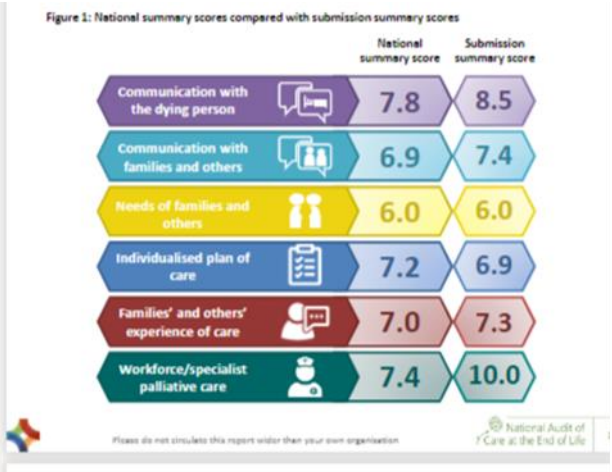
MKUH participated in 100% (4 out of 4) of national confidential enquiries (NCEPOD) in which it was eligible to participate.

2021/22 National Clinical Audit Participation

Audit	Milton Keynes University Hospital
Falls and Fragility Fracture Audit (includes the Hip Fracture Database) (FFFAP) The Falls and Fragility Fracture Audit has been managed as a programme (FFFAP) designed to audit the care that patients with fragility fractures and inpatient falls receive in hospital and to facilitate quality improvement initiatives.	In the National Hip Fracture database, MKUH performs at benchmark for the measured criteria. Falls data has been submitted for the NAIF audit. Falls are reported both on the performance dashboard (as a metric) and in a narrative Quality Account. These reports go to Clinical Quality Board and Executive Management Board. An escalation and assurance report on falls goes to Quality and Clinical Risk Committee (chaired by a Non-Executive Director). This Committee reports on issues, actions and assurances in relation to quality and clinical risk to the Trust Board. Falls as a risk has been raised at safety meetings, and a Quality Improvement Project developed to reduce the risk.
National Cardiac Audit Programme (NCAP) The National Cardiovascular Audit Programme (NCAP) brings together six major cardiovascular domains into one national clinical audit. The programme covers six domains; Adult Cardiac Surgery, Congenital Heart Disease, Cardiac Rhythm Management, Myocardial Ischaemia National Audit Project (MINAP), Heart Failure, Percutaneous Coronary Intervention (PCI).	MKUH is up to date with data submission for all of the arms of NCAP. For the heart failure arm of the audit, the audit suggests good practice in several domains (relatively high rates of specialist input, care in a cardiology setting, cardiology follow-up, and higher than average treatment with disease modifying drugs) suggesting that the investment in heart failure services in 2016 has been beneficial and the service we are providing for the patients we are capturing is good. Reporting highlighted the increase in patient numbers in the 2019/2020 audit (most recent published report) from 308 in 18/09 to 344 in 19/20, representing approximately a >10% year-on-year increase in patient numbers. (Going back 5 years, the audit numbers have increased from 264 - an 80-patient increase, approximately 1/3.) Of note, HES captured 468 heart failure admissions and we submitted > 400 records, so many submissions were excluded.
National Cardiac Arrest Audit (NCAA) The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland	Reports to the Care of the Critically ill group. Challenging data collection. Our numbers are low. The main challenge for the organisation is in completing the of data set. As such, we cannot currently be benchmarked. This may be helped by using e-Care for data collection in the future.
Case Mix programme (CMP) ICNARC The Case Mix Programme (CMP) is an audit of patient outcomes from adult, general critical care units (intensive care and combined	All parameters green and fall well within the 95% predicted range. Low non-clinical transfer rate

intensive care/high dependency units) covering England, Wales and Northern Ireland.	
National Adult Diabetes Audit (NDA) Diabetes is a chronic condition affecting over two million people in England and Wales. It is caused by an inability to use or produce the hormone insulin and leads to a rise in blood glucose. The National Diabetes Audit is considered to be the largest annual clinical audit in the world, providing an infrastructure for the collation, analysis, benchmarking and feedback of local data across the NHS.	NDA data to be collected electronically on quarterly basis. Due to significant challenges on the workload and staffing issues, the diabetes team have not been able to input to the audit.
National Asthma and COPD Audit Programme (NACAP) Programme overview The National Asthma and COPD Audit Programme (NACAP) for England, Scotland and Wales aims to improve the quality of care, services and clinical outcomes for patients with asthma (adult; children and young people) and chronic obstructive pulmonary disease (COPD).	3 metrics are above expectation, but 2 below. The main action plans are 1. Create an 'asthma action pack' and keep them in the Paediatric Assessment Unit to include – smoking leaflet, asthma information leaflet and inhaler technique and asthma action plans. 2. We were planning to start Peak expiratory flow rate (PEFR) measurements in the specialist asthma clinics in select patients 3. Asthma nurse to put prompts on e-Care to help ward nurses to complete the asthma discharge care bundle 4. To identify asthma nurse champions to help support the role 5. To strengthen the nurse led asthma follow up clinic.
National Audit of Breast Cancer in Older Patients (NABCOP) The National Audit of Breast Cancer in Older Patients (NABCOP) will assess the processes of care and outcomes for women aged over 70 years. NABCOP's results will help NHS breast cancer services in England and Wales to benchmark and improve the care delivered to these women. NABCOP will focus on the patient pathway from diagnosis to the end of primary therapy, for women diagnosed with breast cancer from 2014 onwards.	Proportion of patients with recorded ER+ status -86% Proportion of patients with recorded ER+ status- 89% Proportion of patients with recorded ER+ status -68% Proportion of patients with recorded HER2 status -97% Proportion of patients with recorded HER2 status - 98% Proportion of patients with recorded HER2 -96% Proportion of patients with recorded TNM and M (metastatic disease) components, where all 3 reported) - 90% Proportion of patients with TNM stage all 3 reported - 92% Proportion of patients with TNM all 3 reported-79% Proportion of patients with performance status (WHO PS) - 38% Proportion of patients with recorded performance status - 27% Proportion of patients with recorded performance - 34% Proportion of patients (non-screen detected) receiving a triple diagnostic assessment in a single visit [50-69 years] -92%

<table>
<tr><td></td><td>Proportion of patients (non-screen detected) receiving a triple diagnostic assessment in a single visit [70+ years] - 100%
Proportion of patients seen by a breast clinical nurse specialist (CNS) [50-69 years] -100%
Proportion of patients seen by a breast clinical nurse specialist (CNS) [70+ years] -100%</td></tr>
<tr><td><u>National Audit of Care at the End of Life (NACEL)</u>

The audit is focusing on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. Outputs from this project will be of interest to those who receive, deliver and commission care, so will have a far-reaching audience.</td><td> 

The trust has improved in some areas compared to the previous audit- particularly in communication with the dying patient</td></tr>
<tr><td><u>National Audit of Dementia (NAD)</u>

The National Audit of Dementia examines aspects of the care received by people with dementia in general hospitals in England and Wales. It is managed by the Royal College of Psychiatrists' Centre for Quality Improvement. It builds upon earlier rounds of the audit going back to 2010 which were also managed by the Royal College of Psychiatrists.</td><td>Data from 2020/21

<table>
<tr><th>Scoring</th><th>National Score Round 4</th><th>Your hospital score Round 4</th><th>Your hospital rank Round 4 (out of)</th><th>Your hospital score Round 3</th><th>Your hospital rank Round 3 (out of)</th></tr>
<tr><td>Governance</td><td>68%</td><td>15.6</td><td>191 (195)</td><td>56.3</td><td>121 (199)</td></tr>
<tr><td>Nutrition</td><td>89%</td><td>87.5</td><td>102 (195)</td><td>93.8</td><td>70 (199)</td></tr>
<tr><td>Discharge</td><td>76%</td><td>95.8</td><td>19 (191)</td><td>76.8</td><td>86 (195)</td></tr>
<tr><td>Assessment</td><td>87%</td><td>87.4</td><td>107 (191)</td><td>86</td><td>84 (195)</td></tr>
<tr><td>Staff rating communication</td><td>66%</td><td>65.5</td><td>101 (182)</td><td>61.6</td><td>135 (182)</td></tr>
<tr><td>Carer rating: communication</td><td>66%</td><td>-</td><td>- (141)</td><td>75.5</td><td>24 (148)</td></tr>
<tr><td>Carer rating of patient care</td><td>73%</td><td>-</td><td>- (141)</td><td>76.7</td><td>47 (148)</td></tr>
</table></td></tr>
<tr><td><u>National Gastro-Intestinal Cancer Audit Programme – National Bowel Cancer Audit (NBoCA)</u></td><td>128 patients submitted in 2020.
Adjusted 30-day unplanned readmission rate 8.3%
Adjusted 2-year mortality (%) 23%</td></tr>
</table>

The bowel cancer programme audit is delivered jointly by the Royal College of Surgeons (RCS) Clinical Effectiveness Unit, NHS Digital, and the Association of Coloproctology of Great Britain and Ireland (ACPGBI). NHS Digital provides project management and technical infrastructure, while the ACPGBI provides clinical leadership and direction	Patients with complete pre-treatment staging & recorded performance status 100% (green) Better than national in length of stay. Our data collection continues to improve year on year and we are either better or on par with network/national in terms of the various other parameters including rectal cancers. Our rectal cancer surgery volumes are also well above the minimum required at Trust level
Oesophago-gastric Cancer (NAOGC) The aim of the National Oesophago-Gastric Cancer Audit (NOGCA) is to measure the quality and outcomes of care for patients diagnosed for the first time with oesophageal or gastric cancer in NHS hospitals in England and Wales, and so support OG cancer units in the UK to improve the quality of the care received by patients.	Some of these recommendations can be applied locally but others especially those related to surgical procedures are not applicable. All UGI cancer patients who are fit for surgery (early stage) should be referred to a tertiary centre (OUH). We are green for those parameters that we can report.
National Emergency Laparotomy Audit (NELA) This audit of a high mortality (c 15%) emergency surgery seeks to improve the key determinants of outcome. It focusses on pre-op prioritisation based on risk assessment, pre-op imaging and antibiotics, timely access to theatre and critical care and appropriate input from consultant surgeons and anaesthetists.	Data entry has been limited in the last quarter, so MKUH may register as having low numbers. Achievements include high case ascertainment, consultant presence, high risk, rapid access to surgery scoring for cases, high planned admission rate to ITU. Risks have been identified as: 1. CT scanning does not count as consultant-delivered as it is outsourced. 2. No geriatrician link 3. No ED lead.
National Lung Cancer Audit (NLCA) The National Lung Cancer Audit (NLCA) was developed in response to the finding in the late 1990s that outcomes for lung cancer patients in the UK lagged behind those in other westernised countries and varied considerably between organisations within the UK. The audit began collecting data nationally in 2005, and since then has become an exemplar of national cancer audit. In 2015 the Royal College of Physicians won the tender to run the audit for the next three-to-five years.	Data was submitted. MDT has seen the latest report and actions agreed. Data entered by lung cancer nurses using the Somerset database. 4 metrics are in line with benchmark, 1 below expectation.

National Maternity and Perinatal Audit (NMPA) Using timely, high-quality data, the National Maternity and Perinatal Audit (NMPA) aims to improve the treatment of mothers and babies during their stay in a maternity unit by evaluating a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.	MKUH participates in all of the MBRACE streams. A working or review group reviews performance quarterly and report on the Division dashboard. The Learning from SARS-CoV-2-related and associated maternal deaths in the UK – Most of the recommendations have been updated. Processes modified. Flowchart created. Next step is to tie these together. The MDT group reviews PMRT.
National Neonatal Audit Programme (NNAP) Established in 2006 to assess whether babies admitted to neonatal units in England and Wales receive consistent and high-quality care as measured by adherence to a set of agreed professional guidelines and standards. The audit aims to identify areas for quality improvement in NNUs in relation to the delivery and outcomes of care.	Rolling audit – Interim Report has been received. Identified some improvements. One issue – lack of an actual transitional care unit. A business case has been put forward. This is a building work – sits with estates. There is a designated named space. Reviewed in CIG meetings.
National Paediatric Diabetes Audit (NPDA) Diabetes is a chronic condition affecting over two million people in England and Wales. It is caused by an inability to use or produce the hormone insulin and leads to a rise in blood glucose. This clinical audit aims to improve the care, outcomes and experiences of children and young people with all types of diabetes treated within NHS Paediatric Diabetes Units (PDU) until the age of 24 years.	Rolling audit – lots of good feedback – better than benchmark, 89.8% of patients receiving all key care processes annually. Already excellent relationship between Paediatric diabetes specialist nurses (PDSNs) with schools as notes in Peer Review 2020. Established group sessions with additional training. Patient Reported Experience Measure (PREM) results reviewed in a multi-disciplinary team (MDT) meeting with actions. We provide access to specialist diabetes advice to patients and their families 24 hours per day and 7 days per week. We Provide access to a psychologist with experience in diabetes to all children and young people Self-management is discussed in clinic and documented as part of annual review process in SPARKLE database Families in need of support discussed at post meeting MDT meetings and regular Diabetes specific safeguarding meetings with Lead Safeguarding doctor and lead Safeguarding Nurse. Transition to adult care services process starts at age 12years with slow introduction of independent clinic time in a supported way. This develops over time with increasing discussions being centred on independent management. Prior to 16 birthday plans for family to meet an adult diabetes specialist nurse (DSN) before the formal Transition clinic with adult service once 16 years. Time of

	move to adult service decided jointly by patient, family and MDT at a time that is suitable for the young person.
National Audit of Seizures and Epilepsies in Children and Young People	Started 2020 – no final outcomes yet. We have 6 recommendations – have been done - red referral criteria. One issue – epilepsy specialist nurse – business case put forward. Everything else is green and implemented.
National Prostate Cancer Audit (NPCA) Prostate cancer is the most common solid cancer in men with 40,000 new cases diagnosed each year in the UK and its incidence is increasing.	The reports from British Association of Urological Surgeons (BAUS) published in March 2021 have been reviewed for actions. MKUH meet NICE guidance and BAUS benchmarking standards
Sentinel Stroke National Audit Programme (SSNAP) This audit assesses the quality of the organisation and delivery of multi-disciplinary inpatient stroke health services in England, Wales and Northern Ireland. It audits the care provided for patients during and after they receive inpatient care following a stroke	The Advanced Nurse Practitioner (ANP) has previously reported to the Clinical Effectiveness and Audit Review Board (CAEB) that this audit is being undertaken and that we for the period of Jan to March 2021 and have maintained our A grading for performance. An audit of compliance with the CT head angiogram stroke protocol demonstrated excellent results with time ranges from 0-18 mins from time of request to attendance on CRIS. The average time of 7 mins has improved from 10 mins in 2019 and 33% patients were scanned within 2 mins of request. 48% in 5 minutes. 70% within 10mins. It is clear from the data that the excellent communication between the CT team and the stroke team enables scans to be performed swiftly and efficiently from the time of request to the scan.
The National Joint Registry (NJR) The National Joint Registry records, monitors and reports on performance outcomes in joint replacement surgery in a continuous drive to improve service quality and enable research analysis, to ultimately improve patient outcomes	Excellent data entry acknowledged by NJR with certified accreditation. FY 2021-22 and we achieved 97.5% compliance with consent rate for the Trust and we are 100% compliance on our data submission. Infection rates significantly decreased to 0.5% following a QI intervention.
Trauma Audit and Research Network (TARN) The Trauma Audit and Research Network (TARN) is the National Clinical Audit for traumatic injury and is the largest European Trauma Registry, holding data on > 800,000 injured patients including > 50,000 injured children.	High hospital case ascertainment. Adjusted survival rate -2. In 2019 report, 3 metrics were above expectation, 1 in line & 0 below expectation. New TARN lead looking at improvement processes. Clinical governance cases are either reviewed internally or in the TVTN meeting
Learning Disability (LD) Mortality Review Programme	MKUH audited 'Do not attempt cardiopulmonary resuscitation' (DNACPR) processes relating to decision-making during COVID-19. Those with learning disability

The LeDeR programme reports on deaths of people with learning disabilities6 aged 4 years and over7	were found to have a slightly higher DNACPR rate. No overt bias was found, but the numbers were very small.

2.5 Participation in Clinical Research

The National Institute for Health Research (NIHR) which is mainly funded by the Department of Health and Social Care has as its main objective improvement of the nation's health and wealth through research. It plays a key role in the Government's strategy for economic growth, attracting investment by the life-sciences industries representing the most integrated health research system in the world.

MKUH is committed to delivering high quality clinical care with the aim to provide patients with the latest medical treatments and devices and offer them an additional choice where their treatment is concerned.

Patients who are cared for in a research-active hospital have better overall healthcare outcomes, lower overall risk-adjusted mortality rates following acute admission and better cancer survival rates. Furthermore, health economic data shows that interventional cancer trials are associated with reduced treatment costs, benefitting the NHS financially. These benefits may result from a culture of quality and innovation associated with research-active institutions. There is a reasonable further assumption that departments and clinicians within the hospital, who are research-active, provide better care. In turn, this suggests that it is desirable to encourage as many clinicians and departments to become research active as is practicable.

An increasing number of patients receiving relevant health services provided or sub-contracted by MKUH in 2021/22 were recruited to participate in National Institute of Health Research (NIHR) studies approved by a research ethics committee. In 2021/22 over 4,576 patients were recruited to 106 studies in the Trust. The Research and Development (R&D) Department received over 780,000 for 2021/22 to deliver NIHR portfolio research.

This year the team has continued to grow to support the increasing research activity across the Trust. The budget award for 2022/23 is still to be finalised, however it is expected to be over £800,000. there will be an increase in funding for this financial year, to support the delivery of first-class research our patients and local community.

The Department has supported and delivered training of new research staff at MKUH and through network supported training programmes. e.g. Virtual and on-line Good Clinical Practice (GCP) training, Principal Investigator study support services, and study specific training. These courses are open to our staff and other research staff across the Thames Valley and South Midlands Clinical Research Network.

The Trust has continued to develop strong links with local universities and industry. Our partnership with the University of Buckingham, including the state-of- the-art Academic Centre continues to allow us to attract, train and retain the best clinical staff.

Our research activity has contributed to the evidence base for healthcare practice and delivery, and in the last year (2021/22) over 60 publications have resulted from our involvement in research, demonstrating our commitment to improve patient outcomes and experience across the NHS.

The R&D team, managers, research nurses and other research staff also delivered much of the mask FIT testing at MKUH and have worked tirelessly to support the key COVID-19 studies and to maintain critical non-COVID-19 studies throughout the

pandemic. It is worth restating our view that the pandemic demonstrated in the clearest way possible the importance of resilient health and social care systems, the importance of staff, technology and materials and the critical importance of data and of clinical and basic science research in tackling the challenges of the pandemic. We hope that this will lead to greater investment in research and development in the future to tackle other challenges such as developing life-saving therapies for cancer, heart disease and inflammation.

From 2019-20, the participant experience survey (PRES) has been made a Higher-Level Objective by the Department of Health and Social Care (DHSC) in recognition of the importance of participant experience of feedback to both the DHSC and the NIHR. It is carried out to help continually improve the experience of taking part in health research and gives participants chance to feedback on what went well and what could be improved. Over the past year the importance of Research has been spotlighted. During this time patients have welcomed the approaches from the research team and have been willing to trial the medications which were thought to have potential to improve outcomes in the fight against COVID-19. Being supernumerary allowed us to spend some time with isolated patients during the research process, provide some reassurance and meet some of the patients' comfort needs. This, along with keeping the clinical teams informed of the progresses in research was felt to be beneficial for all. Many patients reported that they felt we were offering them a lifeline in the possibility of an additional treatment. Although we ensured all participants understood there may be no benefit, we felt they had more hope and optimism.

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

Over the last 12 months the organisation has continued to identify new ways of raising the profile of research and development within the Trust and our local community. This has been achieved by supporting and working with local media, local events and using social media to publicise and educate about research and research opportunities. The team supports national events such as International Clinical Trials Day, and International Nurses' Day and local events such as the MKUH schools project, Event in The Tent, building relationships with research teams across the network and in primary care. Team members are being creative and finding new ways to raise awareness across the Trust, for example, 'bite size' research interviews from research teams to inform and educate patients and staff.

2.6 Goals agreed with Commissioners

The Commissioning for Quality and Innovation (CQUIN) payment framework for 2020/21 was suspended due to the COVID-19 pandemic.

2.7 Care Quality Commission (CQC) Registration and Compliance

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

- Urgent and Emergency Services
- Medical Care
- Surgery
- Critical Care
- Maternity and Gynaecology
- Services for Children and Young People
- End of Life Care
- Outpatients and Diagnostic Imaging

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

Milton Keynes University Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.7.1 Review of Compliance of Essential Standards of Quality and Safety

The Trust had an unannounced focused CQC inspection in April and May 2019 to check how improvements had been made in Urgent and Emergency Care, Surgery, Medical Care including Older People's Care Service and Maternity Services. In terms of 'safe', medical care was given a rating of 'good' (from 'requires improvement' in 2016); in Surgery, 'safe' was regraded from 'good' to 'requires improvement'. In urgent and emergency care, the rating for 'well-led' was amended from 'good' to 'requires improvement.' All other inspected areas maintained their previous ratings.

There were a number of areas that were not inspected – these were critical care, outpatients, diagnostic imaging, children and young people's services and end of life care. These areas retain their "Good" ratings awarded in October 2016.

2.7.2 Overall Ratings for Milton Keynes University Hospital:

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

2.7.3 Key Findings from the CQC Inspection Report:

Are services safe?

- Medical care including older people's care and maternity services were rated as good.
- Urgent and emergency care and surgery were rated as requires improvement. Not all staff had completed mandatory training, infection prevention and control processes were not always followed, emergency equipment was not always checked daily as per Trust policy, medicines were not always stored correctly and not all safety results and performance met the expected standard.

Are services effective?

- Urgent and emergency care, surgery, medical care including older people's care service and maternity services were rated as good. The hospital provided care and treatment based on national guidance and evidence of its effectiveness; staff assessed and monitored patients regularly to see if they were in pain, staff were competent for their roles and understood their roles and responsibilities in relation to consent and under the Mental Health Act (MHA) 2003, the Mental Capacity act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Are services caring?

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

- The services inspected were rated as good, the Trust mostly planned and provided services in a way that met the needs of local people, patients' individual needs were taken into account; the Trust treated concerns and complaints seriously, investigated and learned lessons from them, although some complaints were not always responded to within the timelines of the Trust's complaints policy.

Are services well-led?

- Surgery, medical care including older people's care service and maternity services were rated as good. The Trust had managers at all levels with the right skills. The Trust collected, analysed, managed and used information well to support all its activities. They had effective systems for identifying risks, planning to eliminate or reduce them. The Trust engaged well with patients, staff and stakeholders.
- Urgent and emergency care was rated as requires improvement because not all managers had undergone formal leadership training and some did not have the capacity to carry out all aspects of the leadership role, including ensuring patient risk assessments were always completed.

2.7.4 Areas of Outstanding Practice

The CQC chose to highlight the following as areas of outstanding practice at the Trust:

In maternity:

- Two new smartphone apps for pregnant women had been introduced, which enabled women to take more ownership and management of their care on a day-to-day basis.
- In December 2018, the Warm Baby Bundle red hat initiatives was rolled out across the maternity service for babies at risk of hypothermia and in extra need of skin-to-skin contacts.
- An online patient portal was introduced to empower patients to manage their own health care appointments.
- In January 2019, pregnant women who had uncomplicated pregnancy were offered the option of an outpatient induction of labour.

In medical care:

- There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met those needs, was accessible and promoted equality.
- The wards ensured that patients were given activities and welcome packs. Staff really promoted independence, enabling patients to eat dinner at tables, take part in group activities and ensure they were ready for discharge.
- The service was supported with social workers and dedicated ward discharge teams, where there was effective communication, and the discharge process was discussed at parts of the patient's journey.

2.7.5 Areas of Compliance or Enforcements

The Trust received no notifications of compliance or enforcement actions as a result of this report.

Areas were identified for improvement, and the Trust took immediate action to ensure those recommendations were acted upon:

In urgent and emergency care:

- The service took action to ensure that immediate life support and paediatric immediate life support training compliance was in line with Trust targets.
- The service took action to ensure that staff are complaint with hand hygiene and personal protective equipment guidelines providing staff with additional training.
- A system was developed and implemented to ensure that all emergency equipment checks are done in line with Trust policy.
- Additional patient risk assessment training was provided to staff.
- The service to action to ensure compliance with local and national audits.

This has been implemented to ensure compliance.

In relation to surgery core service:

- A robust plan of action was implemented to ensure compliance in basic life support training for all staff and safeguarding training compliance for medical staff is in line with targets.
- Enforcement of procedure for checking controlled drugs and accurate records maintained.
- Enforcement of staff compliance with personal protective equipment, safe handling of dirty instrumentation and bare below the elbow's guidelines.

2.8 Data Quality

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

1) The Data Quality Governance Meeting (DGM) is embedded within the Trust governance framework which continues to review the data quality across the Trust. The DGM seeks to receive audit and compliance reports and additional reports highlighting the data quality underpinning key performance indicators enabling the triangulation of poor data quality and oversee actions plans to address them.

2) The continued work of the Systems/Training team has a remit to provide expert advice and guidance on matters of system data quality and a dedicated, ongoing data quality training programme. The Systems/Training team receive feedback from compliance audit reports and areas of poor data quality otherwise identified and work with the Divisions to identify and training needs and support staff with system use. In addition, this team continues to develop supporting documentation and training resources to reduce the risks of poor data quality through poor data entry and developing SOPs (standard operating procedures).

3) Fully developed system assurance reports covering key Trust systems used in support of patient care. Where areas of poor practice have been identified which have contributed to poor data quality, Executive Directors have developed action plans to address these shortcomings. The development of action plans and monitoring the delivery of actions is undertaken by the DGM. The Trust has committed to expanding the delivery of system assurance reports to cover all Trust systems as part of ongoing improvements to data quality in the next financial year.

All of the above activities retain a focus on continued learning and development in a bid to improve data quality and not settling on the status quo. In addition, the Trust is actively engaged with its commissioners to monitor the quality of clinical services delivered through the delivery of local and national targets; these include both quality and performance indicators and hence data quality is important to ensure accurate reporting.

The Trust submitted data records during 2021/22 to the Secondary Uses Services (SUS) for inclusion in the Hospital Episode Statistics (HES). It has maintained data completeness over the national average across the activity areas of inpatients, and outpatients for ethnicity and outpatients for NHS number completeness. The table below provides further information on the data completeness for national indicators NHS number and ethnicity*, with national averages.

Data item	Admitted[1]	Outpatients[1]	A&E[2]
Completeness NHS number	99.6 (99.6)	99.8 (99.7)	96.6 (96.6)
Completeness ethnicity	99.1 (95.5)	98.1 (93.3)	92.1 (92.1)

1 Admitted / Outpatient figures taken from the national SUS+ data quality dashboard – national average in brackets was the latest set of information available at the time of writing this report (M9 DEC 2021).

2 A&E figures taken from the Emergency Care Data Set data quality dashboard - national average in brackets was the latest set of information available at the time of writing this report (8th Feb 2022).

2.9 Qualitative Information on Deaths (While Maintaining Patient Anonymity)

Milton Keynes University Hospital NHS continues to implement National Quality Board guidance regarding Learning from Deaths. This includes quarterly publishing of qualitative and quantitative data on deaths at Trust Public Board meetings.

The Trust has successfully implemented Medical Examiners since May 2019 and now has a team of 10 Medical Examiners. This includes Hospital Consultants from a wide range of specialties to provide a breadth of clinical experience and expertise and Senior General Practitioners. The Trust's medical examiner office plans to extend the Medical Examiner system to scrutinise deaths from all non-acute settings in Milton Keynes.

The Medical Examiner will refer cases for investigation through Trust processes and make appropriate referrals to the Coroner. The Medical Examiner service has received positive feedback from bereaved families and encouraged positive communication with the Coroner's office.

Medical Examiners provide independent scrutiny of all hospital deaths assessing the causes of death, the care before death and facilitate feedback from the bereaved. All deaths undergo review by the Medical Examiner System. Deaths with concerns will undergo a formal Structured Judgement Review. Structured Judgement Reviews are carried out by trained reviewers who look at the medical records in a critical manner and comment on all specific phases of care. The Structured Judgement Review is presented at the Mortality and Morbidity Meetings. Lessons learned are disseminated within the specialty and Trust wide through local Clinical Governance Meetings.

Opportunities for learning from some deaths that were identified to have sub optimal care include, review of pathways for trauma in elderly patients/nonverbal patients, review of inpatient falls assessment, medicine management and improvement in education and training in eCare use including endorsement of results.

The Learning Disabilities Mortality Review (LeDeR) programme is established in the Trust to review the deaths of people with a learning disability, to learn from those deaths and to put that into practise. The Trust reported 5 deaths to the LeDeR programme in the last financial year The Trust has a full-time learning disability coordinator who supports the pathway for the SJR process with LeDeR review. This takes place as part of the BLMK review group and allows for independent review. Recommendations from the review are put into practise. Some of the actions we are taking include improving communications with families, learning disability awareness to ensure adjustments, assessments and formal processes such as DOLs are followed. We now have a specialist Learning Disability Nurse to advise and support staff, carers and patients.

We reviewed the processes for our perinatal mortality reviews. All perinatal losses that meet threshold are reported to the Perinatal Mortality Review Tool (PMRT). The cases undergo an investigation by the team and learning from PMRT is disseminated via different forums and meetings as well as the maternity newsletter. Some of our

actions we are taking involves reviewing and updating all guidelines, staff education, workshops to improve fetal monitoring and strengthened governance.

The data for Q1, Q2, Q3 and provisional Q4 are illustrated in the table below.

Investigations of Deaths 2021/2022

	Q1 Apr-Jun 2021	**Q2 Jul-Sep 2021**	**Q3 Oct-Dec 2021**	**Q4 Jan-Mar 2022**
No. of deaths	205	241	391	278
No. of deaths reviewed by Medical Examiner†	100%	100%	100%	100%
No. of Structured Judgement Reviews (SJRs) Requested by Medical Examiner	10.1%	6.6%	6.6%	9.1%
No. of Coroner Referrals taken for investigation by the coroner (%of total)	13.7%	9.5%	14.1%	10.4%
Mortality and Morbidity (M&M) review selected as per policy	21	21	19	12
COVID-19 RCA Policy	1	9	4	5
No. of Part As	10.7%	7.0%	9.7%	12.5%
No. of Urgent Release – completed paperwork within 24 hours	100% (5)	100% (5)	80% (5)	100% (4)
Medical Certificate Cause of Death MCCD) completion within 3 days	89.3%	90.1%	90.3%	93.5%
No. of Relatives directed to PALS	19	7	7	4
No. of MCCD rejected after medical examiner scrutiny	7	10	5	2

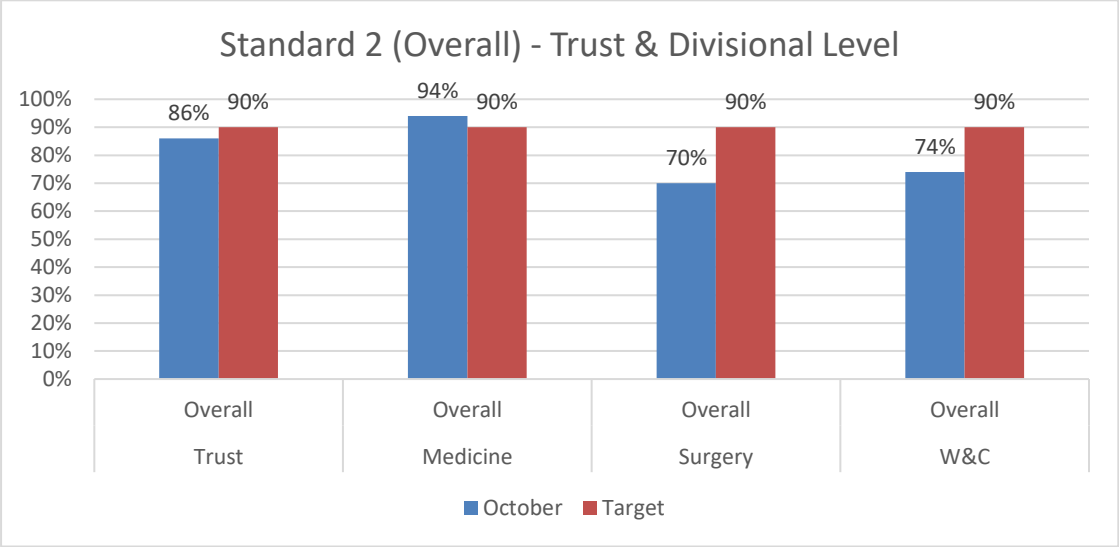
Mental Health or Learning Disability	0	2	3	0

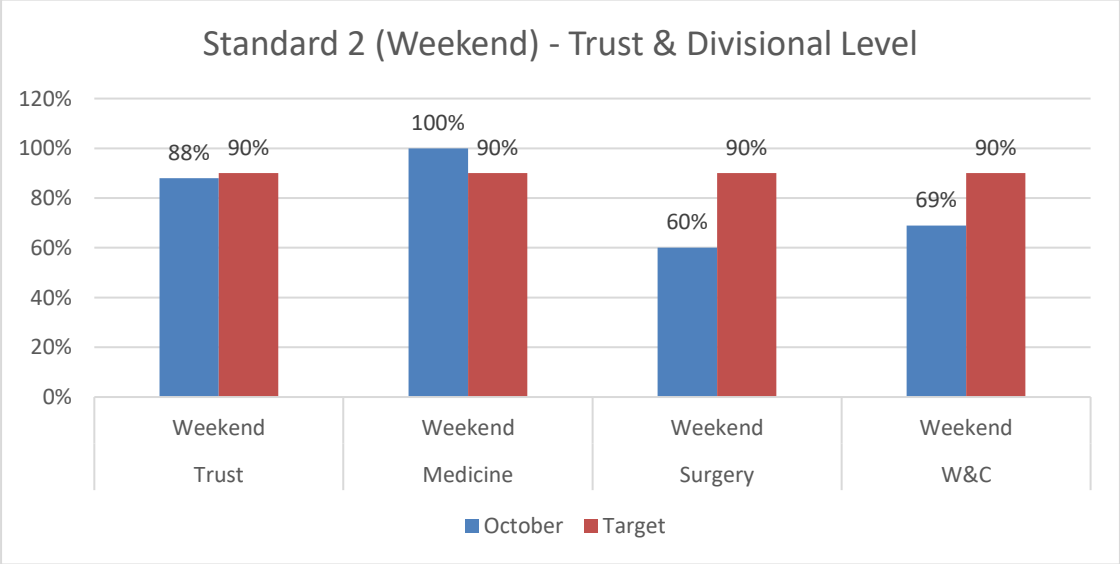
Individual cases where care quality concerns are identified are discussed at the mortality review group, and information / learning is shared with Trust Board of Directors and its Committees. During 2021/22, medical examiners will continue to work to increase the proportion of cases in which they identify potential care quality concerns in order to feed into the structured judgement review process.

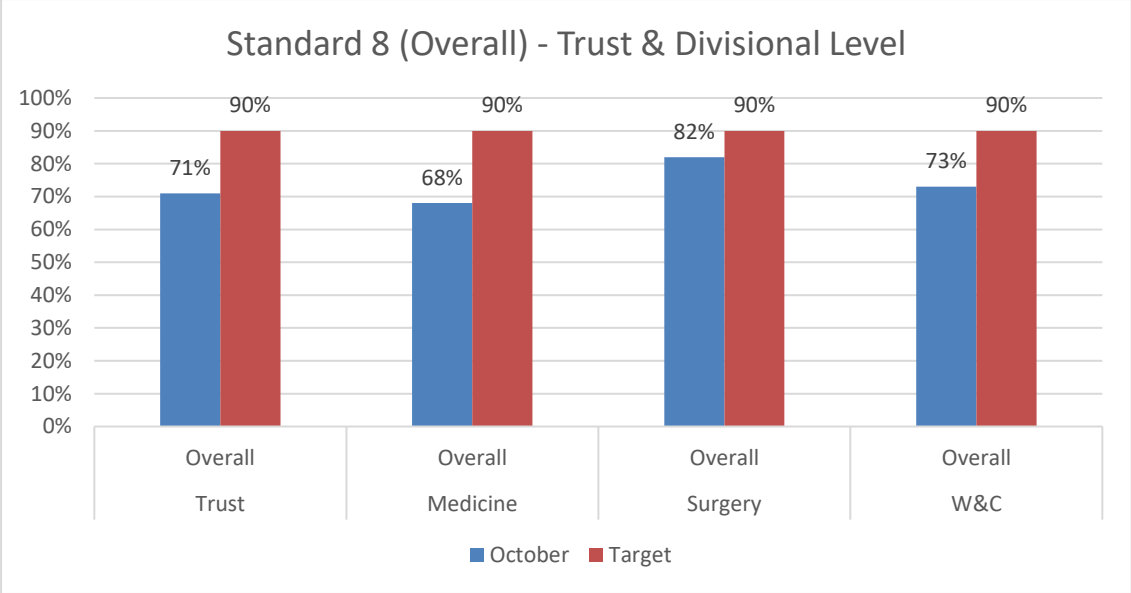
2.10 Seven Day Services

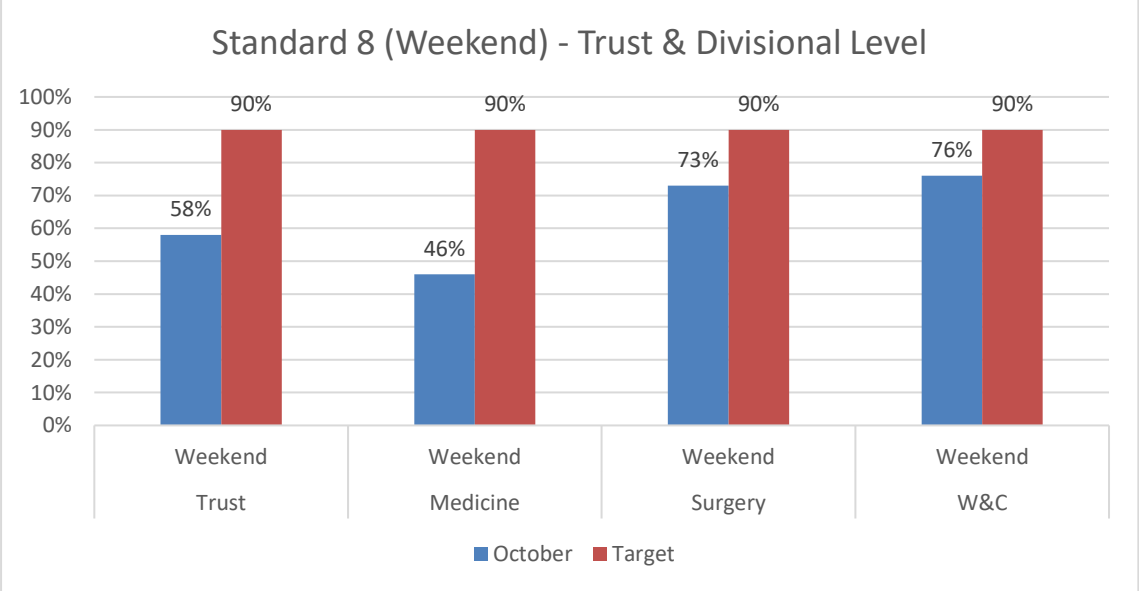
The 7 Day Service (7DS) standards have been defined by NHS England and focus upon the care provided to patients admitted to hospital on an emergency basis. The ten standards are divided into four priority standards and six others. It was expected that organisations were compliant with the priority standards by April 2020, although the onset of the COVID-19 pandemic inevitably reduced focus on this area.

At MKUH, work on the 7DS standards is led by the Medical Director's Office. Progress against the four priority standards has been measured through data arising from a weekly audit of 60 randomly selected patients discharged following an emergency admission in the prior week. These audits were not routinely conducted during 2021/22 (on account of pressures related to COVID-19), although a snapshot was undertaken in October 2021 to assess current status:









Performance across the Trust was good for Standard 2 (consultant review within 14h of admission) in the context of COVID-19, only narrowly missing the target. Performance in relation to standard 8 (daily documented consultant review for inpatients) was further from target but stable since prior to the pandemic. Of note, medicine (which account for much higher patient volumes) achieves very well for standard but struggles in relation to standard 8.

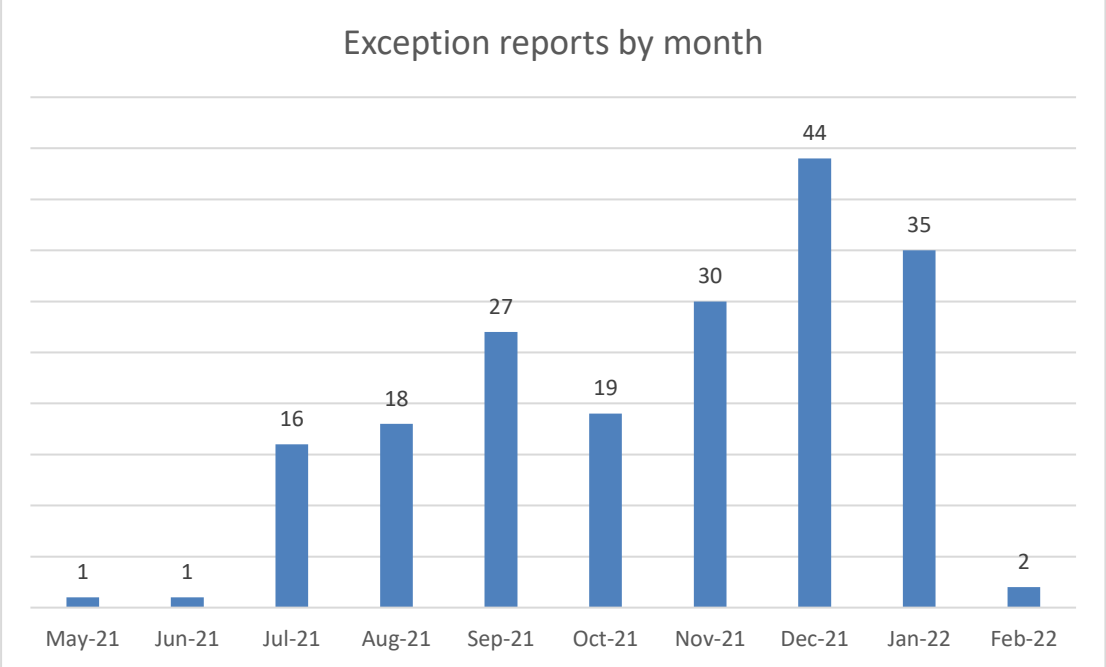
The Medical Director's Office aims to reinstitute regular audits to track monthly compliance and demonstrate improvement into 2022/23.

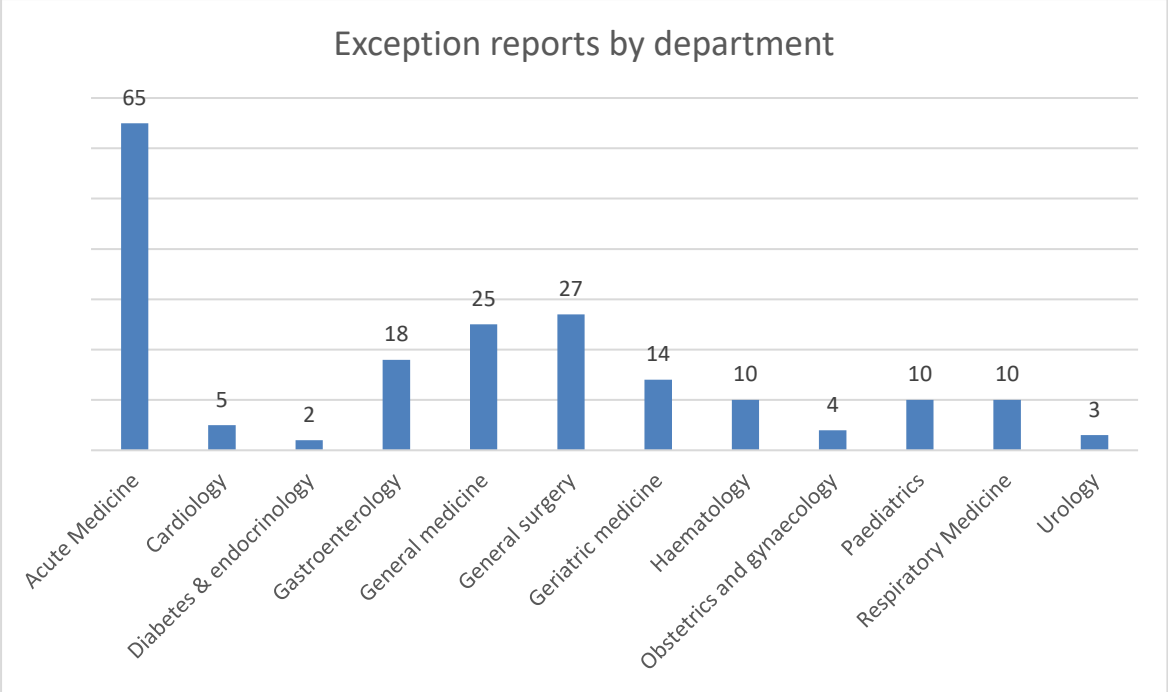
2.11 Report by the Guardian of Safe Working Hours

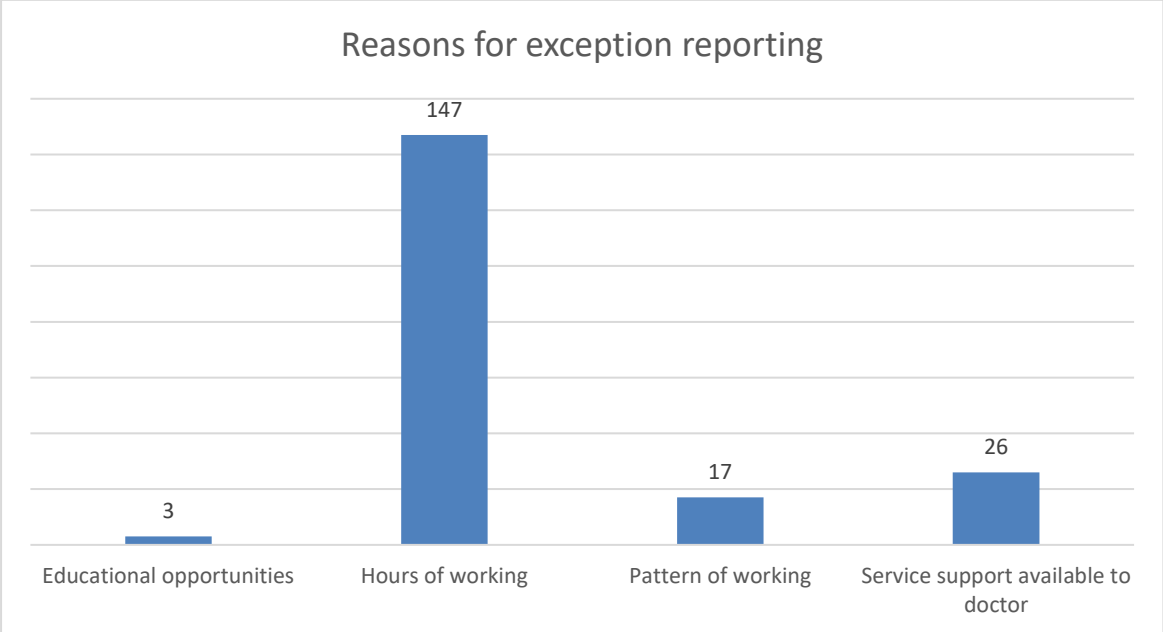
In 2016 a new contract for doctors in training was introduced nationally by NHS Employers. This updated contract placed several new requirements on the employing trust, including (but not limited to) changes to the rules on which rota designs could be based, the additional requirement for work schedules, the implementation of an exception reporting system, the appointment of a Guardian of Safe Working Hours and the setting up of a junior doctor forum to discuss these issues.

Exception reporting is the process where a trainee doctor can raise issues with their educational supervisor in relation to one or more of: their hours of work; the level of support offered to them by senior colleagues; or training opportunities which vary significantly from those described in their work schedule (supplied to them at appointment). Either the Educational Supervisor or Rota Co-ordinator, as chosen by the junior doctor, then reviews the exception report with the trainee and decides what action to take as a result. Exception reporting should then inform staffing, rota and training designs to improve the working conditions for doctors in training. The Guardian of Safe Working Hours governs this process ensuring exception reports are reviewed by both educational supervisors and service leads, and also that issues arising are feed directly to Trust Board through an annual report. Quarterly reports are also provided to the Trust Workforce and Development Assurance Committee.

During the financial year 01 April 2021 – 01 March 2022 the following exceptions have been reported:







Reports peaked from November to January with 56% (109) of the entire year's exceptions being raised in these three months alone. Most exception reports were raised by FY1 trainee doctors in Acute Medicine and FY1 trainee doctors in General Surgery.

76% (147) of reports relate to hours exceptions and 1.55% (3) to educational issues, 13.5% (26) to service support and 8.8% (17) due to work patterns.

2.12 Opportunities for members of staff to raise concerns within the Trust

At MKUH we have several routes by which our staff can speak up. These include:

- Peer to Peer (P2P) – staff volunteers
- Professional bodies
- Health and Wellbeing department
- Regulators
- Freedom to Speak Up Guardians and Champions
- Friends and Colleagues
- Mental Health First aiders
- Mentors and Preceptors
- Line managers
- Confidential staff helpline

Of the routes for speaking out over concerns ranging from patient safety, quality of care, bullying, to incivility, we encourage staff members to use the Freedom to Speak Guardian. The team includes a Freedom to Speak Guardian, two other Guardians and seven Freedom to Speak Up Champions who act as signposts to the Guardians.

There is clear support from the Chief Executive Officer and Board lead for Freedom to Speak Up. The Trust has a comprehensive and accessible Speaking Up Policy which supports how colleagues can raise concerns with the FTSU Guardian Champions and ensures that confidentiality is afforded to those individuals as a matter of course. Anonymity is possible and for all witnesses we strive to ensure that they are protected from detrimental behaviour because of having raised a concern. In addition to the policy, there is Trust-wide signage outlining the names and contact details of the FTSU Guardians and Champions (telephone number and email address). A postcard has also been developed that is handed at staff induction for example. Feedback is given directly to colleagues who raise a concern and, in-turn, feedback received from those making disclosures indicates that the facility to raise their concerns and have them heard, often for the first time, has been beneficial.

In the period April 2021 to March 2022 there has been twenty-one cases recorded and reported to the National Guardians Office, from 6 cases reported in the previous 12 months. The Lead Guardian is using the East of England regional Guardians group and other resources to seek ideas to improve the uptake of the Guardian service. Staff who have spoken up in the past have not reported any detriment to them for doing so. During the same period, there were 1019 contacts made to the Trust's informal and confidential P2P (Peer to Peer) listening service.

The current Lead Guardian has had opportunities in 2021-22 to speak to various managers, and newly recruited Healthcare Support workers. Further opportunities to raise the FTSU profile are being developed. This will be helped by the Trust offering Guardians allocated time for FTSU activities.

MKUH is about to introduce Freedom to Speak Up into mandatory training for staff by using the video learning supplied by the National Guardians Office.

There is a dedicated email address freedomtospeakup@mkuh.nhs.uk for staff to contact the Guardians, and there is a mobile telephone line 07779 986470 as another way of contacting the Guardians, particularly for staff who do not normally use email.

2.13 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.

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

SHMI Table

Domain 1: Preventing People from dying prematurely							
12. Domain of Quality	**Level**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**
(a) The value and banding of the Summary Hospital-level Mortality Indicator ('SHMI') for the trust	**MKUHFT**	1.04 (Band 2)	0.99 (Band 2)	1.05 (Band 2)	1.09 (Band 2)	1.16 (Band 1)	1.07 (Band 2)
	National	1.0	1.0	1.0	1.0	1.0	1.0
	Other Trusts Low/High	*It is not appropriate to rank trusts by SHMI*					
(b) Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust	**MKUHFT**	43%	47%	48%	47%	54%	53%
	National	30%	32%	34%	36%	36%	39%
	Other Trusts Low / High	*0% / 56%*	*12% / 60%*	*14% / 60%*	*12% / 59%*	*8% / 59%*	*11% / 64%*

The Summary Hospital-level mortality (SHMI) reports at Trust level across the NHS using a standard and transparent methodology. SHMI has a lag presentation time period of 6 months. The Trust's SHMI remains at statistically 'as expected'. The Trust remains committed to monitoring the quality of care through mortality review processes to identify themes, areas for improvement as well as good practice. Our aim is to create a learning environment from deaths. All deaths at MKUH are reviewed by the independent Medical Examiner.

b. **Indicator 11: % of admitted patients risk assessed for VTE**

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm							
23. Domain of Quality	**Level**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Patients admitted to hospital who were risk assessed for venous thromboembolism (Q3 results for each year)	**MKUHFT**	85.6%	76.9%	96.8%	98.0%	Not Available	Not Available
	National	95.8%	95.4%	95.7%	95.3%		
	Other Trusts Low/High	80% / 100%	76% / 100%	55% / 100%	72% / 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.

During 2021/22 the Trust made effective use of eCare, its electronic patient record system to simplify the data collection process.

NB: Due to the Trust's response to the COVID-19 pandemic, VTE Assessments were suspended in 2020/21 and remained suspended in 2021/22

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

24. Domain of Quality	**Level**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**
C.difficile infection rate per 100,000 bed days (Hospital-onset)	**MKUHFT**	6.0	7.1	8.6	5.1	6.5	Not Available
	National	13.1	13.6	12.2	13.6	15.4	
	Other Trusts Low / High	0 / 82.6	0 / 90.4	0 / 79.8	1 / 51.0	0 / 80.6	

NB: The national data for 2021/22 is not yet available from NHS Digital.

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

There were 7720 Patient Safety incidents reported last financial year. This equates to a reporting rate of 70.22 incidents per 1,000 bed days. Of these 28 (0.36%) were categorised as Major/Catastrophic. It should be noted that the COVID-19 pandemic resulted in a significant reduction in the number of bed days (due to the reduction of non-emergency admissions), particularly during peak times. This has resulted in a significant increase in the reporting rate per 1,000 bed days (from 51.64 in 2019/20).

The Trust reports patient safety incidents onto the National Reporting & Learning System (NRLS). NHS England uses the data to monitor incident trends NHS-wide

and they produce a bi-annual report (the report will be annual from September 2021) comparing the Trust to other acute organisations. The reporting rate of all incidents has increased however, the Trust continues to be a low reporting organisation. Actions have been put in place to continue to increase awareness of the importance of reporting incidents and to encourage the reporting of incidents. In addition to this, the Trust is moving to a new risk management system in October 2021 with a view to making incident reporting quicker, easier for staff which in turn should increase the rate of reporting.

e. **Responsiveness to Inpatient Needs**

The Trust's Patient and Family Experience Team continues to work with the clinical teams with a view to improving the experience of patients and their families. There are a number of channels by which patients and their families are able to provide feedback, and the Trust responds proactively to these emerging messages. In November 2019, the Board of Directors approved a new Patient Experience strategy. Following the pressures of the COVID-19 pandemic easing, the Trust can now focus on ensuring the strategy is implemented and acted on across the Trust.

NB: Due to the impact of COVID-19 and the pause placed on the Friends and Family Test nationally, the Friends and Family test was not implemented between April 2020 and December 2020.

Domain 4: Ensuring that people have a positive experience of care							
20. Domain of Quality	**Level**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Responsiveness to inpatients' personal needs	**MKUHFT**	64.6%	63.1%	64.5%	62.6%	Not Available	Not Available
	National	68.1%	68.6%	67.2%	67.1%		
	Other Trusts Low / High	60.0% / 85.2%	60.5% / 85.0%	58.9% / 85.0%	59.5% / 84.2%		

Domain 4: Ensuring that people have a positive experience of care							
20. Domain of Quality	**Level**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Staff who would recommend the trust to their family or friends	**MKUHFT**	69%	66%	68%	70%	76%	Not Available
	National	65%	70%	70%	71%	74%	
	Other Trusts Low / High	*48% / 91%*	*47% / 89%*	*41% / 90%*	*41% / 88%*	*50% / 92%*	
Patients who would recommend the trust to their family or	**MKUHFT**	96%	97%	96%	96%	94%	94%
	National	96%	96%	96%	96%	100%	99%

friends (Inpatient FFT - February in each year available)	Other Trusts Low/High	76% / 100%	82% / 100%	76% / 100%	80% / 100%	41% / 100%	77% / 100%

Part 3: Other Information

3.1 Patient Experience

3.1.1 Complaint Response Times

The total number of complaints received for 2021/22 totalled 1042. When compared to 2020/21 this amounts to an increase of 25.7% (2020/21 n= 829).

All complaints are triaged by severity upon receipt. The number of complaints received by severity for 2021/22 is detailed below: -

Red - Severe harm	1
Amber - Moderate Harm	170
Yellow - Low Harm	857
Green - No Harm	14

In percentage terms the number of no and low harm complaints amounts to 83.6% (80.94 % 2020/21) of total complaints received.

Low and no harm complaints are those that are usually dealt with by the PALS team on an informal basis, and are in relation to issues such as appointments, staff manner and attitude and lost property.

Severe and Moderate harm complaints are those that usually involve historical issues or a number of care issues in respect of the patient's care pathway. These complaints are dealt with by the Complaints team and require an in-depth investigation by the responsible division and either a written response from the Chief Executive or a local resolution meeting with the complainant and the responsible staff or both.

A complaint that is made verbally and resolved to the person's satisfaction within one working day is not reportable under national complaint regulations.

All complaints are dealt with in accordance with 'The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009'. The regulations dictate that all complaints should be acknowledged either verbally or in writing within three working days of receipt and should be responded to in full within 6 months.

To ensure that complainants are provided with a timely response to their complaint and investigations are undertaken in a timely manner, the Trust has set its own internal timescales for dealing with complaints and these are set at 60 working days for severe harm (red), 30 working days for moderate harm (amber) complaints, and 15 working days for no and low harm (yellow and green) or within timescales agreed with the complainant.

Divisional compliance with these timescales is monitored and reported through the Trust's scorecard which is reported to the Board monthly. The target for responding to complaints in the timescales agreed with the complainant is set at 90%. The Trust has achieved an average monthly performance of 77.8%. To note is that due to the Trust's changeover to a new event reporting system, it was not possible to provide an accurate performance for the months of November and December 2021. During this year the Trust have seen an increase in the number of patients attending through the emergency pathways. This coupled with an increase in staff sickness absence resulted in complaint investigations being delayed especially when the Trust was in Opel 4 escalation. Consequently, there have been delays in the drafting of complaints response letters in.

A bi-weekly RAG rated report is shared with the divisions through each division's senior team and regular meetings are held with the complaints office and the division to chase any outstanding investigation requests. Where escalation has not been successful each individual case is escalated to the appropriate Executive Director with a request for their assistance in obtaining the overdue report.

3.2 Patient Safety

3.2.1 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. The Trust incident reporting policy outlines duty of candour compliance in line with national regulatory and standard contract requirements. For patient safety incidents reported as a moderate grading or above an initial apology is required where it is recognised that there have been care/service delivery omissions that have resulted in significant harm, followed by a formal written apology. This is tracked on the Trust's electronic reporting system where a dashboard reflects live compliance with both the first & second stages. duty of candour data is included as a Trust KPI and reported at corporate governance meetings. The Trust's Head of Risk & Clinical Governance has lead responsibility with delegated responsibilities within the Risk Management Team for day-to-day management. All duty of candour letters are approved by the Head of Risk & Clinical Governance and her details given as a point of contact if required. For all serious incidents reported on the Strategic Executive Information System (STEIS) a formal duty of candour apology letter is sent which includes offering the patient /relatives the opportunity to be involved in the investigation and a further letter sent on completion of the investigation. Meetings with patients/relatives have been helpful, with fact to face communications enabling an empathetic apology and discussions on the key learning being taken forward.

Duty of candour letters are further included in root cause analysis (RCA) action plans which are tracked by the Trust’s commissioners until all evidence is received to show completed, from an assurance perspective. 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. 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. In 2019 this has evolved further with the introduction of Medical Examiners and their communications with families.

During the COVID-19 pandemic, all possible/probable nosocomial (health care acquired) deaths related to COVID-19 had a case review completed in coloration with the clinical and infection control teams, with letters sent to the next of kin with a copy of these reviews and supporting COVID-19 background information.

The 2021/22 Service Quality Performance Reports report full compliance based on the DATIX duty of candour dashboard live data and is provided at month end (last working day) against a performance denominator of 0.

3.2.2 Preventing Future Death (PFD) Reports

The Trust received 2 PFDs from HM Coroner in the year 2021 – 2022 which related to:

September 2021

Concern expressed in relation to:

- Staffs' awareness of the Royal College of Anaesthetists campaign video "Capnography in Cardiac Arrest: No Trace = Wrong Place"
- Staff's failure to undertake any confirmatory checks, notably looking for the presence of a capnography trace or expiratory misting, to check correct placement of the endo tracheal tube when the patient deteriorated
- Evidence of an inhibitory hierarchical structure which prevented others shouting out
- The team malfunctioning and did not operate as a team with inappropriate delegation of an irrelevant task
- The variable and different configurations with respect to the displays on the ventilators in different theatres and anaesthetic rooms and Intensive Care Unit (ICU) through the hospital. This was confusing for staff and had potential to put patients at risk.

These were also sent to Professor Chris Whitty, Chief Medical Officer for England and Professor Ravi Mahajan, President Royal College of Anaesthetists.

Agreed Trust actions were:

- Systems and processes – the Trust has implemented the Royal College of Anaesthetists quick reference handbook in theatres and standardised monitor configuration across theatres
- Environment and culture – continuing with an extensive programme of simulation training and huma factors training, including the commissioning of a bespoke human factors programme from Cranfield University. Continuing to work with staff across the multi professional theatre team on teamwork raising concerns and flattening the hierarchy. This involves optimising team communication, advocating the freedom to speak up route and a programme of 'appreciate enquiry'

October 2021

Concern expressed in relation to:

- A lack of birth plan and the midwives did not attempt to complete one. There was therefore no indication as to the mother's preferences for treatment and care throughout her labour
- Delivery by the use of Kielland's forceps that resulted in a catastrophic spinal cord injury. The Hospital should carry out an urgent review of the use of Kielland's forceps and decide that they should no longer be used.

A letter was also sent to the Royal College of Obstetricians and Gynaecologists (RCOG).

Agreed Trust actions were:

- A review of maternity pathways to ensure that women's birth preferences are discussed and documented
- Await the response of RCOG noting that it is unlikely that they will remove rotational forceps from practice. In that event if an individual chooses to maintain the option of using them, the Trust will support them in doing so ensuring that knowledge, skills and volume meet requirements

3.2.3 Serious Incidents (SIs) & Never Events

The Trust reported 2 Never events in the year 2021 – 2022 both wrong site surgery in Ophthalmology and Gynaecology.

The Trust reported 120 SIs in the year which can be broken down as follows:

SI Category	Number of Incidents
Pressure Ulcer	25
Delayed Diagnosis	13
Sub-optimal care of the deteriorating patient	7
Drug Incident (general)	16
Surgical error	2
Slips, Trips, Falls	3
Maternity Service - Unexpected admission to NICU	11
Maternity Service	6
Maternity Service - Intrauterine Death	3
IT Equipment Failure	1
Safeguarding Vulnerable Adult	1
Safeguarding Vulnerable Child	3
Unit Closure (COVID-19 outbreaks)	4
Treatment delay	2
C diff/healthcare acquired infection	4
Communication	1

Child death	1
Venous thromboembolism (VTE)	10
Unexpected death of an adult	1
Screening incident	2
Wrong site surgery	2
Maternal incident	1
Flood/environmental issues	1
Total	120

The Trust's Serious Incident Review Group (SIRG) consisting of staff from across the Multi-Disciplinary Team, reviews all incidents reported on DATIX/RADAR at moderate and above, commissioning deep dives and working groups in respect of themes/trends which are monitored via SIRG's action log. Key themes in 2021/22 were:

- New pressure ulcers – Harm Prevention Group focusing on this with a particular focus on continence relating to initial moisture lesions, therapy interventions with patients and those that were device related, with a deep dive looking all plaster of paris incidents over the past 3 years.
- The number of medication incidents. Working group established initially focusing on Parkinson's medications.
- Matrons and Senior Nurses looking at scoring system and documentation by nursing staff in relation to cannula case and linked infections.
- Hospital acquired venous thromboembolism (VTE) and the accuracy of VTE assessments and the inclusion of anti-embolic stockings as part of eCARE electronic prescribing.
- The impact of deviations from usual patient pathways or patient allocations on outlying wards in relation to care delivery, where staff are less knowledgeable about certain conditions.
- The continued increasing volume of patients with mental health needs and the limited resources for specialist beds

In November 2021 the Trust moved to a new incident reporting system called RADAR making us the first Trust in the country to link and report incidents from their system directly into the LFPSE system. The LFPSE system is a national system that all NHS providers must send patient safety incidents onto, in order to help identify national trends and learning to improve practices across the NHS.

The Trust has piloted a new approach to incident investigation, using what is termed the 'SAFE' (Support and Action Following Events) and has been developed to reflect and prepare for the proposed national Patient Safety Incident Response Framework (PSIRF), set to be launched later this year. This approach is more collaborative and enable the staff and patients involved to share their perspective of events and the impact this had.

Learning is shared in local and Trust-wide newsletters and governance reports for clinical improvement meetings (CIGS), with escalation reports to corporate

governance committees. SIRG also has an agenda item for 'spotlight on safety' flagging key learning points from the meeting to be included in the CEO weekly newsletter sent to all staff. The Trust also has the Greatix system for sharing learning and congratulating individual staff.

3.2.4 Midwife to Birth Ratio

Midwives are present at all births and are the main providers of antenatal and postnatal care. Staffing needs in both hospital and community settings depend on service design, buildings and facilities, local geography and demographic factors, as well as models of care and the capacity and skills of individual midwives. Other significant variables with an impact on staffing levels include women's choice and risk status.

To provide a safe maternity service, the Royal College of Midwives (RCM) says there should be an average midwife to birth ratio of one midwife for every 28 births. The ratio recommended by *Safer Childbirth (The Kings Fund)*, is also 28 births to one WTE (whole time equivalent) midwife for hospital births and 35:1 for home births.

At Milton Keynes the Midwife to Birth Ratio is stated on the obstetric dashboard on a monthly basis and reported at Management Board, Women's CSU meetings and Clinical Quality Board bi-monthly. For 2020/21 the Midwife to Birth ratio was reported as follows:

Month	**Midwife to birth ratio**
April 2021	1:33
May 2021	1:31
June 2021	1:34
July 2021	1:34
August 2021	1:34
September 2021	1:33
October 2021	1:35
November 2021	1:33
December 2021	1:35
January 2022	1:31
February 2022	1:33
March 2022	1:33

The average ratio for 2021/22 was 1:33.

3.2.5 Statutory and Mandatory Training

Statutory training is that which an organisation is legally required to provide as defined by law or where a statutory body has instructed organisations to provide training based on legislation.

Mandatory Training is that which is determined essential by an organisation for the safe and efficient running in order to reduce organisational risks, comply with policies, and meet government guidelines.

MKUH Mandatory training competencies are mapped to the Core Skills Training Framework. There has been a steady improvement in statutory and mandatory training – the table below shows the compliance rate by year and at the end of each quarter.

	Q1	Q2	Q3	Q4
2015/2016	86%	87%	88%	89%
2016/2017	89%	89%	90%	91%
2017/2018	91%	89%	90%	89%
2018/2019	90%	89%	90%	93%
2019/2020	93%	92%	94%	94%
2020/2021	94%	95%	95%	97%
2021/2022	96%	96%	96%	94%

Mandatory training is reported at Workforce Board, Workforce and Development Assurance Committee (quarterly) and Trust Executive Committee (monthly). During 2020 ESR self-service was developed with all training except Manual Handling (Level 2) and Resuscitation now accessible via its e-Learning platform. The Trust consequently no longer uses workbooks routinely and the movement to e-Learning has been of particular timely use during the pandemic. The Trust has also adopted use of the national principles of the pay progression framework to support increasing levels of compliance into 2022/23

3.3 Clinical Effectiveness

3.3.1 Cancer Waits

There are more and more people being diagnosed with cancer and living with the condition. Current figures show that one in two people will be diagnosed with cancer in their lifetime, and it is expected that by 2030 3.4 million people will be living with cancer and beyond cancer.

At the time the NHS Long Term Plan was published in January 2019, cancer survival was at the highest it has been – and thousands more people survive cancer every year. For patients diagnosed in 2018, the one-year survival rate was nearly 74% – over 10 percentage points higher than in 2003. Despite this progress, improving cancer survival is still a priority and diagnosing cancer earlier is one of the biggest actions the NHS can take to improve cancer survival. Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival.

During the pandemic, Cancer services were asked to prioritise elements of the NHS Long Term Plan that could help with recovery, such as the roll-out of the faster diagnosis of non-specific symptoms across the country, with a further 20 places due to join the programme in 2022. These are important building blocks towards meeting the ultimate ambition of 75% diagnosis at stage 1 and 2 by 2028.

10-Year Cancer Plan: Call for Evidence - GOV.UK (www.gov.uk)

Milton Keynes University Hospital has developed services and continues to develop services in line with the NHS 10-year Cancer plan and has provided a lot of focus on recovery and restore programmes across specialities. Multidisciplinary teams have access to cancer performance targets and a live patient tracking tool to enable the management of patients' pathways and the early identification of delays and trends of issues. There are weekly escalation meetings managed with the Head of Cancer Services with all operational speciality leads to discuss patient level detail and capacity and demand management.

There is a further weekly overview of the cancer position and risks at the Executive Patient Tracking List meeting, alongside this there are escalation alerts sent to the divisional and executive leads for any pathway that is raising concerns and resulting in patient delays. The Head of Cancer services meets with the BLMK CCG lead to review cancer breaches fortnightly and presents root causes analysis and risk assessments for those raising concerns as required and identifying actions in place. Both MKUH and BLMK CCG report the cancer positions back through their Board meetings.

The Trust actively works with the Cancer Alliance and both East of England and the Thames Valley Cancer Strategic Clinical Network on the new cancer standards, striving to provide a faster diagnostic pathway of 28 days to enable patients receiving treatment within the 62-day standard. MKUH have appointed an improving cancer pathway manager who is actively working with the specialist teams reviewing and developing straight to test pathways to support this measure. There is an active cancer clinical improvement group and a leads improvement group where lessons learnt are discussed and developments shared enabling clinical leads to maintain visibility on the whole cancer pathways within the trust.

Milton Keynes University Hospital has also invested in the development of a new Cancer Centre which opened in March 2020 and provide additional capacity and services to the cancer patient groups enabling additional access for patients alongside meeting living with and beyond cancer standards. This has brought together Cancer services under one roof in a purpose-built facility with treatment rooms and a ward specifically designed for these patients.

The Cancer services team have worked to maintain cancer pathways over the COVID-19 outbreak utilising capacity within the independent sector as well as ensuring the opening of the new Cancer Centre enabled local capacity to be protected to continue with treatments on a treatment priority bases. The priority booking during the COVID-19 pandemic saw patients booked according to urgency and patients that could go on maintenance treatments were planned for at a later time. The clocks did not stop for these patients, but their delays were clinically managed and planned into capacity later showing them as cancer breaches and continuing to track them to avoid any patients being missed over this time which reflects in the February 2022 and March 2022 performances. The Cancer services team continue to work closely with the specialities to review any patients waiting over 62 days and ensure harm reviews are undertaken whilst working towards the 62-day recovery trajectory to restore cancer performance.

Cancer performance has been affected by the volume of cancer referrals received over the year with an increase of 2,481 referrals against the March 2020 pre-pandemic position. This has had an increased impact on the diagnostic capacity which is being worked through at the faster diagnostic pathways and restore and recovery meetings.

All patients on the Cancer tracking pathway are clinically reviewed and harm reviews undertaken for patients over 62 days, patients are managed in priority order alongside the performance measures to ensure best clinical practice is maintained.

2-week wait Cancer performance

Tumour Site	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Brain/CNS	100.0%	91.7%	84.2%	90.0%	88.2%	94.1%	100.0%	95.0%	100.0%	100.0%	76.9%	91.3%
Breast	87.8%	92.1%	96.3%	94.1%	92.6%	96.0%	92.8%	89.9%	93.2%	91.8%	92.1%	92.5%
Colorectal	57.1%	81.3%	72.4%	70.9%	64.4%	73.2%	74.9%	75.4%	76.4%	72.1%	72.0%	69.8%
Gynaecology	81.3%	73.5%	75.4%	72.4%	86.4%	88.0%	96.1%	90.3%	81.0%	87.2%	91.9%	86.5%
Haematology	100.0%	77.8%	100.0%	100.0%	100.0%	100.0%	93.8%	92.9%	92.3%	62.5%	100.0%	83.3%
Head & Neck	84.1%	88.8%	92.2%	93.0%	88.5%	92.9%	93.8%	95.2%	87.5%	86.9%	91.1%	95.7%
Lung	83.9%	65.8%	68.8%	65.5%	68.6%	51.5%	73.5%	57.8%	67.2%	72.7%	97.6%	84.5%
Skin	96.7%	96.3%	96.5%	95.7%	95.4%	94.7%	94.7%	88.8%	81.6%	89.4%	97.6%	97.0%
Upper GI	80.6%	82.2%	86.4%	85.2%	78.8%	86.6%	84.4%	79.3%	87.9%	80.7%	91.2%	86.9%
Urology	85.5%	86.2%	98.7%	96.3%	91.1%	94.1%	91.6%	91.3%	91.9%	81.4%	90.3%	87.9%
Other	100.0%	50.0%	100.0%	100.0%	40.0%	57.1%	63.6%	75.0%	77.8%	75.0%	75.0%	100.0%
Paediatrics	100.0%	90.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	64.7%	85.7%	100.0%
Grand Total	**82.0%**	**87.5%**	**88.0%**	**85.9%**	**84.8%**	**88.5%**	**89.3%**	**86.0%**	**84.9%**	**84.1%**	**89.2%**	**88.0%**

28-day Cancer performance

Tumour Site	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Brain	75.0%	100.0%	94.4%	81.8%	93.8%	100.0%	93.3%	93.8%	85.2%	90.9%	80.0%	91.3%
Breast	87.4%	93.3%	93.8%	89.8%	94.6%	95.8%	94.7%	95.0%	94.2%	92.3%	94.8%	93.2%
Breast Symptomatic	91.6%	94.6%	95.7%	96.8%	96.4%	93.1%	95.9%	96.0%	97.6%	91.0%	96.5%	95.0%
Colorectal	76.5%	79.4%	83.0%	77.4%	81.2%	77.6%	73.3%	83.5%	83.2%	75.3%	76.9%	76.7%
CUP	33.3%	100.0%	100.0%		0.0%	50.0%	100.0%		100.0%	50.0%	50.0%	
Gynaecology	33.7%	50.5%	34.7%	45.2%	52.0%	48.4%	54.3%	61.5%	55.9%	39.3%	49.6%	54.0%
Haematology	40.0%	66.7%	44.4%	46.2%	20.0%	16.7%	42.9%	40.0%	58.3%	16.7%	15.4%	18.2%
Head and Neck	52.1%	62.9%	66.0%	57.4%	76.9%	68.0%	65.2%	67.3%	79.2%	59.2%	68.6%	60.3%
Lung	84.8%	80.8%	69.0%	66.7%	81.8%	63.6%	65.2%	64.0%	74.6%	66.7%	62.5%	84.8%
Paediatric	87.5%	84.6%	90.0%	100.0%	100.0%	88.9%	91.7%	90.9%	100.0%	88.2%	71.4%	88.9%
Skin	74.0%	88.3%	77.7%	80.0%	80.5%	79.4%	76.5%	91.4%	79.6%	64.7%	53.0%	73.6%
Upper GI	80.9%	77.8%	64.4%	73.2%	81.3%	63.3%	65.1%	70.2%	70.3%	52.1%	76.1%	65.1%
Prostate	33.3%	25.0%	33.3%	30.0%	0.0%	9.1%	46.2%	7.1%	0.0%	0.0%	0.0%	11.1%
Urology	63.8%	76.5%	79.6%	82.5%	52.6%	61.3%	60.0%	47.7%	48.0%	47.4%	59.7%	51.2%
Grand Total	74.2%	81.6%	78.6%	75.8%	79.5%	76.8%	76.7%	80.1%	79.3%	69.0%	72.1%	75.3%

31-day Cancer performance

Tumour Site	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Brain	100.0%			100.0%		100.0%			100.0%			
Breast	85.2%	83.3%	88.9%	93.9%	96.7%	91.3%	100.0%	96.0%	93.3%	95.7%	100.0%	96.3%
Colorectal	85.7%	76.9%	88.2%	92.3%	85.7%	90.0%	90.0%	92.3%	86.7%	94.4%	95.0%	72.7%
Gynaecology	100.0%	88.9%	80.0%	100.0%	83.3%	100.0%	100.0%	80.0%	100.0%	60.0%		100.0%
Haematology	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Head and Neck	100.0%	100.0%	100.0%	100.0%	60.0%	85.7%	66.7%	100.0%	100.0%	100.0%	75.0%	75.0%
Lung	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	90.9%	100.0%	100.0%	100.0%	100.0%
Skin	100.0%	100.0%	97.4%	100.0%	100.0%	97.4%	100.0%	77.8%	62.5%	76.9%	95.0%	96.0%
Upper GI	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	88.9%	90.0%	100.0%
Urology	93.8%	91.7%	95.0%	100.0%	100.0%	89.7%	95.7%	93.1%	100.0%	100.0%	96.0%	90.9%
CUP				100.0%			100.0%	100.0%				
Paediatric												
Other												
Grand Total	**94.4%**	**92.7%**	**93.7%**	**97.8%**	**94.8%**	**94.4%**	**95.7%**	**93.2%**	**94.0%**	**89.9%**	**95.9%**	**93.3%**

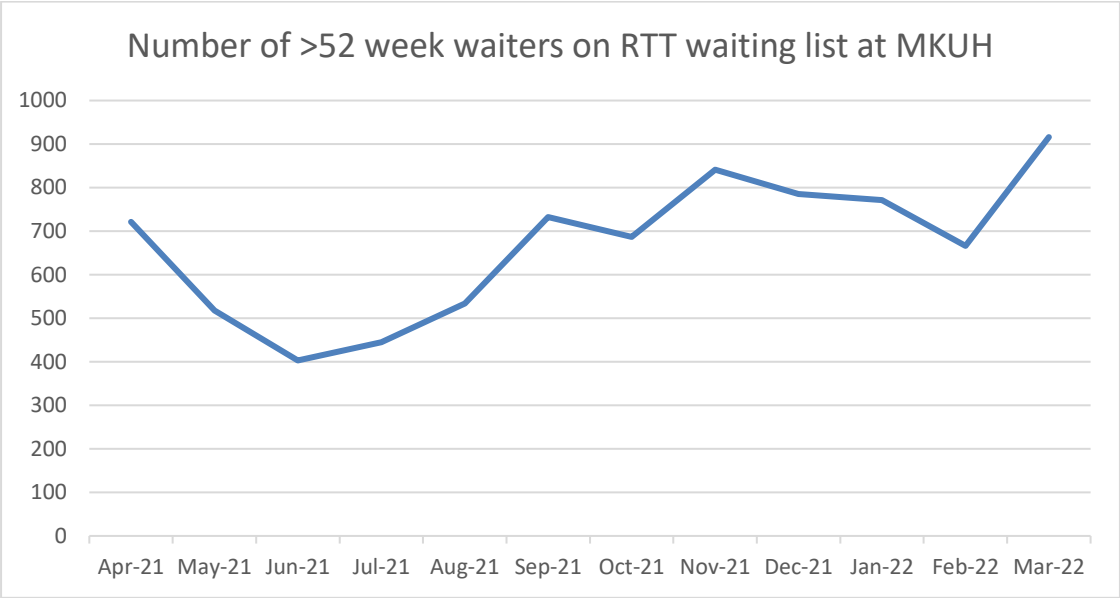
62-day cancer performance

Tumour Site	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Brain									100.0%			
Breast	66.7%	88.9%	73.3%	58.8%	72.7%	76.5%	53.3%	69.2%	72.2%	61.5%	76.9%	69.2%
Colorectal	71.4%	28.6%	18.2%	71.4%	80.0%	20.0%	37.5%	40.0%	30.0%	38.1%	71.4%	33.3%
Gynaecology	12.5%	14.3%	12.5%	20.0%	53.8%	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%	20.0%
Haematology	100.0%				100.0%	100.0%	80.0%	60.0%			100.0%	100.0%
Head and Neck	0.0%	25.0%	0.0%	0.0%	50.0%	18.2%	0.0%	44.4%	0.0%	33.3%	33.3%	0.0%
Lung	66.7%	100.0%	50.0%	33.3%	50.0%	40.0%	77.8%	75.0%	50.0%	0.0%	0.0%	0.0%
Other								100.0%				
Skin	100.0%	88.4%	100.0%	100.0%	97.4%	93.8%	95.8%	88.9%	66.7%	92.1%	87.0%	97.3%
Upper GI		100.0%	100.0%	80.0%	62.5%	58.3%	57.1%	50.0%	50.0%	66.7%	44.4%	0.0%
Urology	94.1%	73.1%	58.3%	85.0%	66.7%	80.0%	70.0%	55.8%	57.1%	75.0%	45.7%	65.7%
Grand Total	81.1%	71.3%	68.9%	76.1%	76.6%	73.7%	68.8%	58.6%	52.7%	66.9%	62.7%	66.7%
Including Rarer Cancers (RC)	**81.4%**	**72.6%**	**68.9%**	**76.8%**	**76.6%**	**73.7%**	**69.1%**	**58.6%**	**53.6%**	**66.9%**	**62.7%**	**66.7%**

3.3.2 Long waiting patients

The impact of the COVID-19 pandemic on the Trust's clinical operations, and the significantly increased activity after the pandemic, has ensured that the number of patients who have waited for 52 weeks or more on the waiting list remain high.

Providing care to patients in a timely manner is a key element of the high-quality services the Trust seeks to offer, and as the hospital recovers from the response to the pandemic, our aim is to return to the position of having no patients at all waiting a year for their planned treatment.



3.3.3 Quality Improvement

Quality improvement is key to improving the safety and effectiveness of the care we provide, and the experience our patients while using our hospital.

Quality improvement teams were redeployed through the pandemic to support clinical care in wards and departments. This has meant the programme has needed to adapt throughout the year.

The focus of the last year has been on introducing and embedding Appreciative Inquiry – a strengths-based, positive approach to encouraging and supporting innovation and learning. This has included educating and training teams on using Appreciative Inquiry in practice – learning from what goes well in the delivery of care to support the adoption and spread of good practice. We have delivered specific programmes on Appreciative Inquiry in Maternity, Theatres and the Emergency Department and worked with the Greatix champions and patient experience teams to promote and increase positive practice.

A new head of quality improvement and quality improvement manager were appointed in the reporting year, who will work with the existing quality, safety, experience and governance teams to continue developing and driving the improvement agenda.

The Improvement Hub and Network

In recognition of the range of improvement methodologies in use, QI (Model for Improvement), AI, Human Factors, Audit, Research and Development, and the Cultural Change Programme, a virtual Improvement Hub team and network continues to be developed.

This brings together the approaches in one virtual area, providing staff with a central point of access to log and access information on the appropriate tools, training, techniques, and to contact staff who lead and are skilled in a particular area to support improvement ideas.

This will facilitate central capture of the improvement work being undertaken, to share and celebrate the small and large improvement work being delivered and enable reporting organisationally.

It is envisaged that a physical Improvement Hub space will be re-established in 2022, with the opportunity for the wider improvement team to be able to work more closely together.

Celebrating Success

We have introduced the CLEAR Pathway (Capturing and Learning from Everyday Experience) to capture examples of experiences and positive practice.

More than 100 people have been trained in and delivered Appreciative Inquiry-led work across the Trust, linking with the positive practice Greatix introduced.

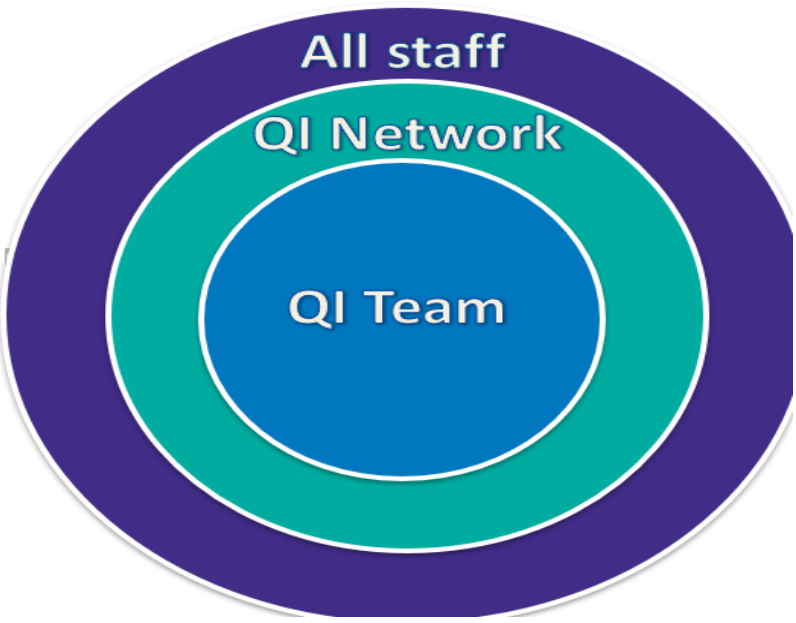
The Improvement Network

The improvement network aims to provide all staff access to improvement skills, learning, ideas and to other staff interested in improvement for mentoring and support.

QI team: People who have QI as part of their main job, co-ordinate QI activity, including training, mentoring, ensuring improvement is captured and encouraged trust wide- application process??

The QI team membership : includes leads from clinical divisions and professional groups, and support services- Multi-disciplinary and multi-professional. Sim, Human Factors, AI, research and audit team

All staff have the opportunity and are actively encouraged to get involved in QI activity through the network- accessible for all staff



Training

Currently, there are training programmes for improvement commencing across the Trust including Appreciative Inquiry, and Human Factors.

Staff can also access online QI methodology training tools provided by Future Learn, NHS Elect and NHS England, and are provided with coaching and support from the QI team in using these tools in their improvement work at a team and individual level.

The Trust leadership programme (with QI modules within them) are due to be recommence in 2022.

has been supported by members of the library and quality improvement team.

Systems, Processes and Sharing

New Appreciative Inquiry-led systems have begun to be embedded, including:

- Exploring and reporting on incidents,
- Meetings with complainants,
- Debriefing with staff after incidents,
- Student experience check in sessions,
- Story elicitation to learn about staff, student partner and patient experience,
- Noticing, reporting and discussing positive practices,
- Appreciative meetings
- Reflective sessions on stories gathered.

Next Year

A new Quality Improvement Strategy has been developed and is due for approval by the Trust Board of Directors in 2022. This combines Appreciative Inquiry with the wider Quality Improvement work, including audit and Getting It Right First Time (GIRFT), in one integrated strategy.

This will be introduced after an Improvement Festival in June 2022, engaging staff in improvement methodologies and spreading the benefit of growing individual and team expertise in positive practice and improvement work.

3.4 Performance Against Key National Priorities

Indicator	Target and source (internal /regulatory /other)	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96% (National)	99.0%	99.6%	99.2%	98.0%	94.5%	95.3%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	85% (National)	86.0%	88.2%	83.9%	81.1%	78.5%	70.6%
Maximum wait of 2 weeks from GP referral to date first seen for all cancers	93% (National)	95.0%	95.9%	96.4%	94.3%	84.1%	86.5%
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments	98% (National)	100.0%	100.0%	100.0%	99.0%	98.3%	98.8%
Maximum waiting time of 31 days for subsequent cancer treatments: surgery	94% (National)	98.0%	100.0%	98.9%	98.6%	84.2%	83.6%
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients	93% (National)	94.0%	96.0%	96.4%	97.5%	92.1%	96.8%
Referral to treatment in 18 weeks - patients on incomplete pathways	92% (National)	92.5%	90.7%	87.4%	85.5%	57.8%	52.5%
Diagnostic wait under 6 weeks	99% (National)	99.6%	99.0%	98.7%	98.9%	83.2%	64.5%
A&E treatment within 4 hours (including Urgent Care Service)	95% (National)	92.1%	91.0%	91.4%	88.8%	93.1%	83.9%
Cancelled operations: percentage readmitted within 28 days	95% (National)	87.4%	67.0%	70.4%	86.5%	50.0%	72.8%

Clostridium difficile infections in the Trust	39 (National)	10	13	15	14	6	13
MRSA bacteraemia (in Trust)	0 (National)	2	3	1	0	1	1

Appendix 1

Statement from Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group (BLMK CCG)

BLMK Commissioning Group acknowledges receipt of the draft 2021/2022 Quality Account from Milton Keynes University Hospital NHS Foundation Trust (MKUH) and welcomes the opportunity to provide this statement.

The Quality Account was shared with BLMK's Executive Directors, Commissioners and Quality Team and systematically reviewed by key members of the CCG's Quality Team as part of developing our assurance statement.

2021/22 has continued to be a very challenging year for the system, with the on-going impact from new COVID-19 variants, support for the mass vaccination and system wide pressures, all whilst working towards recovery of services affected by the pandemic. It is positive to see that all system partners across the Integrated Care System (ICS) are continuing to adapt and develop to deliver safe care to our patients, both at Place and across the wider ICS footprint. We would like to extend our gratitude to staff for their commitment and hard work during this time.

The Quality Account is a well-constructed document which clearly evidences the improvements, innovations, and challenges during the year along with areas of focus for 2022/2023.

Throughout 2020-2021, MKUH have demonstrated their commitment to adopting new and innovative technologies aimed at improving the quality of care. These innovations have included the final implementation phase of the eCARE system meaning the system is now live across all parts of the Trust. The time saved by staff through the use of new technologies allows them to spend more time focusing on treating and supporting patients.

Further work came in December 2021, when the Trust became the first in the country to integrate the new national NHS Learn from Patient Safety Events (LFPSE) service. The new service helps to improve how patient safety events are recorded and will allow for prediction and reduction of future incidents.

In terms of quality improvements, it should be noted that the priorities for 2021/22 were continued from 2020/21 because the delivery of the 2021/22 priorities were significantly impacted by the operational challenges of the Trust's response to COVID-19.

It is positive to see that progress and improvements have been made against the 2021/2022 priorities despite the challenges, and that there are plans to continue to embed and develop some of these priorities into 2022/23.

The first priority, reducing deep tissue injuries – also called pressure ulcers - is an area that has the potential to provide significant improvements in patient safety and outcomes and is one that has produced some challenges over the past year.

The second priority, reducing long waiting times in elective care, will improve patient safety, experience, and the effectiveness of their treatment This is also a national priority for the NHS.

The third priority, reducing discharge delays, will improve patient experience and ensure the health and care system overall is caring for people in the right place at the right time.

For 2021/22, Milton Keynes University Hospital fully participated in the National clinical audit's programmes, with some key learning identified. This together with continued research activity has demonstrated a clear commitment to improve patient outcomes and experience across the NHS. This activity should be commended against the ongoing pandemic challenges.

As recognised nationally, maternity services remain a key national and local area of focus. The CCG anticipate continuing to work collaboratively with the Trust to support on-going developments across the local maternity and neonatal systems (LMNS).and the work being undertaken at MKUH in relation to its action plans resulting from the initial, and recently published Final Ockendon Review. At the time of writing this statement the Maternity Improvement section was not completed but we expect this will further reflect the on-going work across MKUH and the wider system

The CCG is supportive of the Trusts 2022/2023 Quality Account priorities. We also look forward to working closely with the Trust on the implementation of the National Patient Safety Strategy.

BLMKCCG wishes to acknowledge the achievements made during an extremely challenging 12 months and can confirm, to the best of our knowledge, that the Quality Account contains transparent information which is factually accurate and identifies areas of practice for improvement that the CCG continues to support in relation to the range and quality of services provided. The information provides both positive achievements and opportunities for improvement.

2022/23 will be a period of transition for the CCG as it becomes an Integrated Care Board (ICB), but we continue work together to ensure safe and effective care for our patients. We expect that this will reinforce the joint working already in place and enable the 2023/24 Quality Account priorities to reflect the ICB quality and population health priorities.

We hope the Trust finds these comments helpful and look forward to continuous improvements throughout the coming year

Appendix 2

Statement from Healthwatch Milton Keynes

Healthwatch Milton Keynes (HWMK) would like to thank Milton Keynes University Hospital NHS Foundation Trust (MKUH) for inviting us to comment on the draft Quality Account 2021-22.

We would suggest editing for typographic errors and for consistency throughout the document as the capitalisation of terms varies quite widely. It would also be useful, in a public facing document, for a glossary to be provided, especially where acronyms are not explained. It would also be helpful for consistency and understanding to refer to the document as the Quality Account throughout rather than using other terms interchangeably. This is an understandable oversight, as this is the first year that NHS Foundation Trusts have not been required to produce a Quality Report to be published in the Annual report, which would then be reused, as appropriate, as the Quality Account.

It is good to see that the 2022/23 quality priorities so closely align with the priorities held by the NHS nationally and the local Health and Care System, as improvements in these areas will provide substantial positive impacts on the experience of care for patients of MKUH. This alignment will support the continuation of the journey towards a truly integrated care system. It would be useful to better understand the reasons why patients are becoming 'Super Stranded' as the numbers have almost returned to pre-pandemic levels in a very short space of time. Some explanation of what local or regional barriers are causing the delayed discharge would help people to understand the measures taken when they are reported against in next year's Quality Account.

The full participation in the National Clinical Audit Programme is to be congratulated in a year where staff and resources were under immense pressure. Some of the MKUH actions/ data reporting in the table relating to these is very well explained and described. Other areas of the table, the National Audit of Breast Cancer in Older Patients for example, have had statistics copied into them with no explanation of what this means in regard to MKUH's performance against the metrics. The pictures used in other parts of the table may need to be of a higher resolution to allow people to read the text contained. There is also a lot of clinical 'jargon' used which is not explained to the reader.

HWMK were interested to read that the Care Quality Commission review of compliance of essential standards of quality and safety undertaken in 2019 highlighted concerns around hand hygiene and Personal Protection Equipment. We find it concerning as we raised patient concerns around hygiene and infection control processes with the Trust Patient Experience team during the Pandemic and were advised, as we are in the Quality Account, that systems had been implemented to address this.

The section containing the qualitative information on deaths was very interesting and HWMK commend the hospital on the implementation of the Medical Examiner

system. The opportunities for learning , along with the information included later in the Quality Account around patients with Learning Disabilities would be a welcome addition to the 2022/23 Quality Account. The information we have received from patients with Learning Disabilities and neurodiverse patients, and their families, demonstrates to us that MKUH staff are actively working towards improving the experience of this patient cohort. We acknowledge that there is still room for improvement and better understanding and communication. We would commend the actions and efforts of the Hospital and its staff to get this right.

The graphs pertaining to the Seven Day Services and the Report by the Guardian of Safe Working Hours would be better placed after the explanatory paragraph as they only make sense after reading the text. It is good to see the Freedom to Speak Up Guardian and Champions supported and promoted so widely. The text mentions two other Guardians and it would be useful for their Guardianship to be expanded upon.

The section on Preventing Future Deaths in relation to the delivery using Kielland's forceps is not clear. It appears that the coroner has recommended that the Hospital should decide to discontinue the use of these forceps. The following page, if rotational forceps are the same instrument, reads as though the Trust will continue to allow staff to use them if they wish. HWMK have assumed that the 'individual' who will choose to maintain the option is the staff member and not the patient.

The Clinical Effectiveness: Cancer Waits section is an area of concern for many people and it is heartening to see the collaboration and innovative ways of working that MKUH are using to improve patient outcomes through earlier assessment and treatment.

Healthwatch Milton Keynes thanks Milton Keynes University Hospital Foundation Trust for presenting their draft Quality Accounts for 2021-22 and look forward to re-establishing our collaborative and positive relationship as visiting the site becomes easier in the year ahead.