NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Annual Report and Accounts 2017/18

Standing Way
Eaglestone
Milton Keynes
MK6 5LD

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www.mkhospital.nhs.uk

Milton Keynes University Hospital NHS Foundation Trust
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Presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a)
of the National Health Service Act 2006

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This report is based on guidance issued by the Independent Regulator of NHS Foundation Trusts and was approved by the Board of Directors of Milton Keynes University NHS Foundation Trust on 25 May 2018.

Joe Harrison
CHIEF EXECUTIVE

The Annual report can be made available in other languages and formats on request.

Performance Report

Chairman's Introduction

It gives me great pleasure to introduce the annual report and accounts for Milton Keynes University Hospital NHS Foundation Trust (MKUH) for 2017/18.

This is my first annual report as Chairman of MKUH. I was honoured to be appointed to the post after spending a year, from January 2017, as acting chairman following the sad death of our late chair Baroness Margaret Wall.

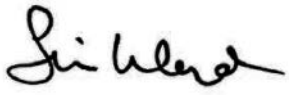
This year has seen a significant number of achievements as the Trust continues to offer safe and effective care to all residents of Milton Keynes and surrounding areas. As well as keeping our focus on the quality of the care that we provide, we have also delivered against our financial plan for the year; ending with a lower (better) deficit position than planned. This builds on the previous four years of delivery to financial plan and sees our financial deficit continue to reduce.

There are lots of exciting developments across the hospital site. Among the highlights of the previous year was the opening of our Academic Centre, in partnership with the University of Buckingham. This facility is a fantastic addition to the hospital site and it will allow us to attract, train and retain the best people to our clinical teams at MKUH. I was honoured to be able to attend its official opening by HRH the Duke of Kent in February 2018. I believe that the Academic Centre will help the organisation tremendously in advancing our vision of becoming a world class medical teaching facility.

The engagement and wellbeing of our 4,000 staff and volunteers is crucial to the effective running of a large hospital. To that end, last May we held our first Event in Tent. This was a staff engagement event designed to provide our staff with a platform to get together to share good practice and ideas and raise concerns. It was an open and honest forum where staff had the opportunity to help shape the future development of our hospital. Over the three days more than 1,000 members of staff attended the various workshops and keynote sessions. It was very well received by staff at all levels and the feedback we have received about the more recent iteration of the event held in May 2018 was that it was even more successful, with a number of high profile and inspirational speakers in attendance.

As a Foundation Trust, MKUH has a Council of Governors which plays a vital role in representing the interests of the hospital's members and making sure that services are meeting the needs of the local community. Currently we have 29 governors, including both staff and public-appointed governors who represent constituencies in Milton Keynes and the surrounding area.

It also gives me great pleasure to acknowledge the tireless support of our Non-Executive Directors. This year we bade farewell to David Moore, who stepped down after his six years on the Board during which he made immense contributions to the organisation. We welcome our three new Non-Executive Directors - Professor John Clapham, Helen Smart and Heidi Travis - and look forward to benefiting from their many years of expertise and experience as we look to the future.



Simon Lloyd
CHAIRMAN

Section 1

Performance Report

Performance Review

1.1 Overview Of Performance

The performance overview provides a summary of the Trust's performance for 2017/18. It includes a statement from the Chief Executive providing his perspective on how the Trust has performed during the year; provides a brief synopsis of the Trust's purpose and activities and on its history and statutory (legal) background. This section also outlines the key risks and issues to the delivery of the Trust's objectives faced by the organisation in 2017/18.

1.1.1 Chief Executive's Statement on Performance

It is a real pleasure to write this introduction and to reflect on what has been a successful and rewarding year for Milton Keynes University Hospital.

We continue to see improvements in care quality and in the facilities and services we provide to the residents of Milton Keynes, Buckinghamshire and beyond, and I am proud that we have managed to achieve such a lot throughout the year.

These achievements have been made possible by the hard work of our staff, and I would like to take a moment to formally acknowledge the professionalism, dedication and commitment of our workforce. We increasingly use the tag #TeamMKUH to articulate the value we place on working together and the value that every individual brings to the team of almost 4,000 people working at the hospital. We ask of and expect a lot from our staff. They are our best and biggest asset and everything we achieve is testament to their dedication, professionalism and passion to provide the best possible care and services to our patients. They are well supported in their work by volunteers, governors, students, members and people from our community, to whom we are also very grateful.

There is a detailed summary of performance in this annual report, and you will see that the number of people seeking emergency care has continued to increase. Although we did not meet the overall four-hour emergency access target for the year, our performance at just under 91% of patients assessed, admitted or discharged within four hours did place us among the top performing hospitals in the country. This demonstrates both the challenge of delivering emergency care when demand continues to rise year-on-year, and the hard work of staff in the emergency department and across the hospital in ensuring patients received prompt care and attention.

Some of our other patient care and quality highlights include the continued reduction in hospital acquired infections and in meeting all our cancer treatment time targets. We are also continuing to deliver priorities set out in our annual quality account – with some really critical campaigns, including improving sepsis care and care for patients who are in their last days and weeks of life. Improving patient experience in every ward and department also continues to be a real focus for us. Looking forward to next year, waiting times for elective care will remain a priority for us.

Along with improvements in care quality, some of the highlights of the year here have been in the development of our estate. We were delighted to open our new main entrance in May 2017. This gives all visitors to the hospital a clear and purpose-built way in to the hospital and it is much closer to our main parking area, the multi-storey car park. It is a bright, airy and welcoming space, with a prominent reception desk, as well as a coffee shop and food outlets, and dedicated offices for our Patient Advice and Liaison Service (PALS), Age UK and Carers MK.

Another major milestone was reached during the year with the opening of the £8.5m Academic Centre, in partnership with the University of Buckingham. This is an exceptional education resource on the hospital site, with state of the art facilities to train medical students, doctors, nurses and allied health professionals. It was opened in February 2018 by HRH the Duke of Kent.

Further construction work is under way to ensure we are still able to offer a good number of parking spaces. A second multi-storey car park should be completed in May 2018 and then work will begin on a very exciting new development – the building of a cancer centre, which will see integrated cancer services collected in one place. This is due for completion in 2019.

Our third Annual Staff Awards took place in October 2017. The awards have gone from strength to strength with more nominations than ever this time in some fiercely contested individual and team categories. Recognising the commitment, innovation and hard work of all our staff is really important to us, and the staff awards are a great way to do that formally every year. Several staff members have also been recognised externally for their work, including our dementia nurse Shadi Maleknia, who was recognised by the Prince of Wales for her services to dementia patients. Shadi was instrumental in setting up our monthly Dementia Café. Inpatients with a diagnosis of dementia and their carers come along for tea and cakes on fine china. They get the opportunity to try their hand at different craft activities, sing and chat to others and it provides them with a welcome break away from the wards and the opportunity to dress in their day clothes.

Looking after the welfare of our staff is essential to enable them to provide a safe, effective and caring service to our patients. We introduced our Peer to Peer (P2P) listening service last year, and to date, almost 1,000 confidential conversations have taken place. Colleagues from across the organisation have been trained as volunteer listeners for those who feel that they would benefit from the service. In addition, this year we have introduced a coaching service for staff who feel that they would appreciate more support as they develop in the workplace. We now have several accredited coaches among our staff who are able to offer this service.

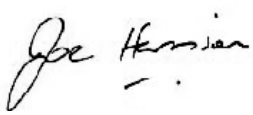
Our status as a teaching hospital continues to flourish and we welcomed the first University of Buckingham third year students to our wards and departments for their placements this year. We continue in our commitment to research too, with many patients successfully participating in a wide variety of diverse research initiatives throughout the year.

Financially, we have met our plan for the fifth consecutive year and have performed better than expected, delivering a deficit position of £16.1m against a planned deficit of £18.8m. 2017/18 has indeed been challenging, with a significant savings programme. This is a significant achievement and one I am pleased to recognise here.

We have also played an active role as one of 16 partners in the Bedfordshire, Luton and Milton Keynes shadow Integrated Care System, as well as developing the Milton Keynes local health and care place-based network, to enhance services across care settings for local people.

Finally, I would like to formally welcome Simon Lloyd who has accepted the post of chairman of our Board of Directors and Council of Governors. Simon takes up the permanent post after spending a year as interim chairman following the sad death of our previous chair Baroness Margaret Wall.

I look forward to another year focused on continuing to improve the care and services we provide to the residents of Milton Keynes, Buckinghamshire and beyond.



Joe Harrison
CHIEF EXECUTIVE

1.1.2 Purpose and Activities of the Trust

Milton Keynes Hospital NHS Foundation Trust was founded on 1 October 2007 under the National Health Service Act 2006. The hospital has around 550 beds, including day acute and neonatal beds and employs more than 4,000 staff, providing a full range of acute hospital services and an increasing number of specialist services to the growing population of Milton Keynes and surrounding areas. All in-patient services and most outpatient services are provided on the main hospital site.

The Trust is organised into four clinical divisions (medicine, surgery, women and children and core clinical) and a number of corporate directorates. The executive directors, and clinical service unit (CSU) leadership teams, are responsible for the day-to-day management and running of the hospital's services, with ultimate management accountability resting with the Chief Executive.

1.1.3. Trust objectives

The Trust Board has agreed a process for agreeing and refreshing its objectives each year, ensuring that these remain linked to its mission, values and strategy. The Trust's mission is set out as:

- A hospital committed to learning, to honesty, and to the best possible care and experience for every patient, every time.
- A sustainable, high performing university foundation trust hospital, providing excellence in care quality, research, education and training.

The Trust's values are:

These are linked to its strategy:

And to its objectives:

MKUH is part of the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Partnership (STP). The BLMK STP is one of 44 STP 'footprints' that have been set up across England under the Five Year Forward View as a new approach to plan and deliver services by place rather than around individual organisations. In June 2017, BLMK was named as one of eight health and social care systems across the country that are to become Accountable Care Systems (ACS). The development of ACS (now referred to as Integrated Care Systems) will see local health and care organisations working more closely together to provide joined up and better coordinated care. MKUH, in conjunction with the other BLMK partners, is working on outline plans for an integrated approach to commissioning, with a view that these will be formalised during the course of 2018/19.

1.1.4 History and Statutory Background of the Trust

Milton Keynes Hospital was officially opened in 1984 and is located at Standing Way, Eaglestone, Milton Keynes, MK6 5LD. The acute services provision at that time included operating theatres, an emergency department, maternity services, general and speciality wards, full diagnostic x-ray facilities, and a major pathology department.

Other projects that were completed soon after this major development included a postgraduate education centre and an extended physiotherapy department, including a hydrotherapy pool.

Construction of phase two started in 1988 and focused on the expansion of facilities to support the continued population growth of Milton Keynes (estimated increase from 1984 to 1994 - 40%). The development comprised six additional 28-bed wards, a further suite of operating theatres, extra accommodation for the pathology department and additional accommodation for staff.

Phase two opened in 1992. Milton Keynes General NHS Trust formally came into being on 1 April 1992. Since then, significant changes have included the expansion of postgraduate education facilities, a new MRI scanning unit and the expansion and re-location of the cardiology unit and coronary care ward. In recent years the site has grown further with the addition of a 28-bed orthopaedic ward, a GP paediatric assessment unit, fracture clinic and refurbishment of the Emergency department.

Expansion continued with the opening of a £1.5m Macmillan Haematology and Oncology Unit within the main hospital. In January 2005 the biggest single development on the site for ten years, a £12m treatment centre dedicated to day cases and extended day case surgery, was opened with 60 bed spaces and a further four operating theatres. The centre has proved very popular with patients.

During 2006/07 the sexual health centre was refurbished and a new £2.5m angiography unit opened. Construction work on a new multi-storey car park was completed in July 2007 and our cardiology services continue to develop. Extra capacity has been added to clinics such as orthopaedics, ophthalmology and a rolling refurbishment of wards and corridors is on-going.

Since becoming an NHS Foundation Trust on 1 October 2007, sustained expansion has continued. During 2008/09 Ward 14, previously run by the local primary care Trust, was fully refurbished and reopened by the hospital. In April 2009 the hospital opened a new significantly expanded £4.6m state-of-the-art endoscopy unit and a new 22 bed ward.

In response to the number of patients requiring step down facilities rather than acute care, the Trust invested in developing a ward into a therapist-led facility for patients on the road to recovery. The Phoenix Unit opened on 5 November 2012 and has 20 beds.

1984

MK Hospital officially opened

1988

Phase **two** commences
Six additional **28** bed wards
Operating theatre suite

1992

Phase **two** opened
MK General NHS Trust
New MRI scanning unit
28 bed orthopaedic ward
GP paediatric assessment unit
Refurbished A&E department

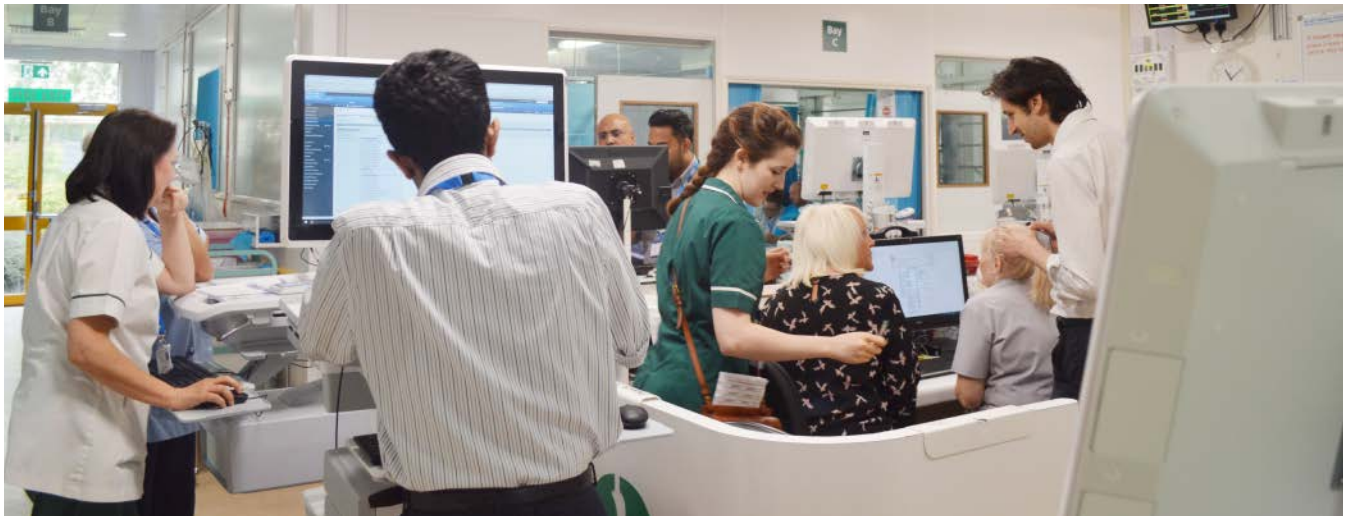
2005

£1.5m Macmillan haematology and oncology unit
£12m treatment centre dedicated to day cases
60 bed spaces
4 operating theatres

A new 20-bed surgical ward, Ward 24, opened in February 2017. Ward 24 will help the hospital manage an ever-increasing demand for services throughout the year and will be used by elective surgery patients. Ward 24 is the first building to be opened under the hospital's site development programme, with a new £5.4m main entrance that opened in May 2017 and the £8.5m Academic Centre opened by HRH the Duke of Kent in February 2018.

In addition to these site developments, 120 professional support staff moved off-site to new offices located in central Milton Keynes in November 2016 to allow the Trust to better utilise space for clinical purposes at the hospital.

The Trust has recruited 2,592 patients to participate in our research projects, with more data still to be included for 2017/2018 recruitment.



The Trust entered into a partnership with the University of Buckingham to establish the first independent Medical School in the country. The first medical students commenced pre-clinical training at the University in January 2015, and in April 2015 the Trust changed its name to Milton Keynes University Hospital NHS Foundation Trust to reflect this status. The first cohort of University of Buckingham medical students began full-time clinical training with the Trust in March 2017. Sixty students will complete their MB ChB course at the hospital over the next two and a half years, with forty students training on site at any one time.

Having submitted expressions of interest for several commercial studies, we were awarded studies in cancer, emergency medicine, cardiology, diabetes and stroke. This demonstrates the Trust's growing recognition by industry, and its success in forging relationships with commercial partners intending to perform quality research. A second grant submission has been made for our collaboration with the Open University to the Medical Research Council. The project would trial the use of fluorescence to detect the spread of cancer during surgery, therefore potentially reducing the number of patients recalled for further surgery. In this project MKUH would act as a sponsor for the clinical trial.

2007

£2.5m angiography unit opened

Development of cardiology services

NHS Foundation Trust formation

Extra capacity for orthopaedics and ophthalmology

Multi-storey car park completed

2009

Ward 14 fully refurbished

£4.6m endoscopy unit and new **22** bed ward

2012

Therapist led facility developed

The Phoenix Unit opens with **20** beds

2015

Partnership with the University of Buckingham to establish the first independent Medical School in the country.

Milton Keynes University Hospital NHS Foundation Trust.

1.1.5 Key Risks and Issues

At the end of 2017/18 the Trust had 24 risks on its Board Assurance Framework, which includes highly scored risks (in terms of consequence and likelihood of the risk materialising) that could affect the delivery of the organisation's objectives. These risks are managed through the risk management processes in place in the Trust, with oversight and scrutiny through executive and non-executive chaired boards and committees.

Summary of key risks and issues as at March 2018:

1. Unsafe practice due to overwhelming demand for emergency care
2. Failure to appropriately embed learning and preventative measures following Serious Incidents
3. Failure to recognise and respond to the deteriorating patient
4. Failure to provide an appropriate patient experience
5. Lack of assessment against and compliance with best evidence based clinical practice through clinical audit
6. Lack of assessment against and compliance with NICE guidance
7. Failure to meet the 4 hour emergency access standard
8. Failure to meet the key elective access standards – RTT 18 weeks, non-RTT and cancer 62 days
9. Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure
10. Failure to adequately safeguard against major IT system failure (deliberate attack)
11. Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/ infrastructure)
12. Failure to successfully deploy eCARE in a way that diminishes disruption
13. Failure to maximise the benefits of eCARE
14. Inability to keep to affordable levels of agency and locum staffing
15. Timing and release of capital and revenue funding
16. Inability to achieve the required levels of financial efficiency within the Transformation Programme
17. Disagreement with main commissioner over the level of performance that they are prepared to fund
18. The Trust is unable to access £7.3m of Sustainability & Transformation Funding
19. The Trust fails to utilise available capital funding according to strategic and clinical priorities
20. Failures in compliance leading to regulatory intervention (CQC)
21. Inability to recruit to critical vacancies
22. Inability to retain staff employed in critical posts
23. Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre
24. Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme

Further detail on risk management is contained within the Annual Governance Statement from page 92 onwards.

1.1.6 Going Concern Disclosure

IAS 1 requires management to undertake an assessment of the NHS Foundation Trust's ability to continue as a going concern. The Trust's accounts have been prepared on a going concern basis as there has been no application to the Secretary of State for the dissolution of the NHS Foundation Trust and the Directors currently believe there is a realistic alternative to doing so. The Directors have therefore prepared the financial statements on a going concern basis.

The current financial environment for all NHS Trusts and NHS Foundation Trusts continues to be challenging with trusts having to deliver recurrent efficiencies in order to combat inflationary pressures and meet financial control totals set by regulators.

For the year ended 31 March 2018 the Trust has a financial deficit of £16.1m (£21.1m deficit for the year ended 31 March 2017) and delivered an improved position against the financial control total set by NHS Improvement by £0.3m before sustainability and transformation funding. However, the Directors consider that the outlook presents significant challenges given the need to deliver on-going efficiency, as well as the Trust's reliance on borrowing from the Department of Health and Social Care to support its cash flow.

The Trust has prepared its financial plans and cash flow forecasts on the assumption that adequate funding will be received from the Trust's commissioners (contractual income), and through Department of Health and Social Care (DHSC) funding facilities. In addition, the Trust has assumed it will receive £10.3m of non-recurrent Provider Sustainability Funding (PSF), the payment of which is contingent on the Trust achieving its agreed financial control total and meeting its agreed performance trajectories during 2018/19.

The Trust expects this to be sufficient to prevent the Trust from failing to meet its obligations as they fall due, and to continue operating until adequate plans are in place to achieve financial sustainability for the Trust. However, the Directors have identified that there are material uncertainties that cast significant doubt over whether the Trust will continue to exist in its current form, and over its ability to discharge its liabilities in the normal course of business.

Funding for the 2018/19 financial year over and above internal generating funds is still to be determined; however it is expected to be through uncommitted revenue/capital term loans as in previous years. This will have the effect of increasing long term liabilities and reducing net assets. The revenue loan facilities have a maturity of 3 years, with no principal being repaid until the end of the term. Capital loan financing is expected to be repaid over a 10 year period.

As part of its 2018/19 financial plan submission, the Trust has requested revenue support of £15.8m and a further £11.3m for capital expenditure (of which £4.7m has been pre-approved by DHSC). In addition the Trust has a revenue loan of £31.2m for which the repayment term has been extended until March 2019. The Trust is waiting for confirmation from DHSC that the loan's repayment period will be extended further.

Positive cash balances can only be maintained throughout the period by successfully securing the necessary funding from DHSC, having a contract with the lead commissioner Milton Keynes Clinical Commissioning Group and receiving £10.3m of PSF.

Image: Paul Studd

The significant risks facing the Trust are summarised as follows:

1. The Trust has prepared a cash flow forecast which shows a minimum daily level of headroom of £1m. There is a level of uncertainty over whether the Trust will receive additional uncommitted loans of £15.8m (revenue) for 2018/19 as well as £3.6m for the period April 19 to June 19 and £11.3m (capital) required to meet its financial obligations.

   In addition there is uncertainty around the amount of PSF the Trust may receive due to funding being split between achievement of the following three elements: the Trust's financial control total; the ICS's control total; and achievement of the A&E targets. However, the Trust has developed its financial plan assuming that it will receive this funding, as well as rolling over existing loans that are due for repayment within the next 12 months, and thus continue on a going concern basis;

2. There is uncertainty over whether the Trust will achieve its efficiency savings plan (circa £10m). This is a level of savings which is extremely challenging and must be supported with adequate clinical focus and engagement in quality process improvement against agreed and appropriately detailed delivery plans.
3. The rate of growth in the hospital's catchment population is expected to be above the national average. If actual growth rates exceed those assumed in the Trust's 2018/19 financial plan, there is a two-fold risk: firstly in the Trust's commissioners' ability to pay for higher levels of activity and secondly in the cost of resourcing unplanned activity.

4. The implementation (planned May 2018) of the Trust's electronic patient record system (eCare) could lead to adverse impacts on the Trust's finances or performance during the transition phase.

5. There remains uncertainty around the potential impact of macroeconomic factors, including those associated with 'Brexit'.

While there are material uncertainties which may cast significant doubt as to the Trust's ability to continue as a going concern and therefore its ability to realise its assets and discharge its liabilities in the normal course of business, the financial statements do not include any adjustments that would result if the going concern basis were not appropriate.

1.2. PERFORMANCE ANALYSIS

This section of the report provides a summary of the Trust's key performance indicators and outlines how it monitors performance against these measures. It also provides a detailed analysis and explanation of the development and performance of the Trust during the year using a wide range of data, including key financial information. This section also provides a summary of key environmental matters and some background on social, community and human rights issues, important events and overseas operations.

1.2.1 Activity

Demand for acute care continued to increase in 2017/18 as the population in Milton Keynes continued to grow and mature. The Trust processed 2.1% more GP referrals than it had planned to, but demand on the emergency department was 1.8% lower than expected. The Trust accommodated 5.6% more emergency inpatient admissions through the year, which undeniably had an impact on planned elective activity, with the Trust handling 7.8% fewer elective admissions than it planned to at the start of the financial year.

The change in activity during 2017/18 was as follows:

- 353,662 outpatient attendances, 1.2% fewer than 2016/17
- 24,444 elective admissions, 4.1% fewer than 2016/17
- 34,184 emergency admissions, 5.9% more than 2016/17
- 87,740 emergency department attendances, 1.1% more than 2016/17
- 3,763 babies were delivered, 1.2% fewer than 2016/17

1.2.2 Key Performance Measures

The Trust continuously measures performance in key service and quality areas against key national indicators, which each have nationally defined standards. In addition, the Trust has developed a series of local quality indicators in collaboration with commissioners, as well as a number of internal indicators of quality and performance that are not reported nationally.

Where possible, relevant and applicable, performance indicators are consistently reported at aggregate Trust level and at Divisional and CSU level to provide granularity. This approach provides insight into performance, and is used to highlight risks and/or uncertainty in specific areas or services. Performance reports and indicators are used as the basis for setting the agenda for regular Trust Board and Divisional performance meetings, alongside financial, workforce and other key pieces of information. This allows links to be made across a wide range of information to drive and inform continuous improvement.

Despite a continued increase in demand and sustained pressure on the healthcare system, the Trust has managed patient waiting times for planned care effectively during 2017/18. Whilst the national standard for consultant-led Referral to Treatment (RTT) waiting times was not achieved in every month due to pressures from the less predictable demand for emergency care and delayed transfers, it was achieved in four months out of the twelve. The Trust has however consistently outperformed the NHS England aggregate performance.

The diagnostic waiting time target was achieved in each month except for one (December). Meeting the national standards for cancer waiting times has also proved to be challenging, but the Trust's aggregate performance has consistently been delivered against the national standards and has also been reliably better than the national aggregate performance.

Indicator	Assessment Benchmark / Target	Trust Performance	Outcome	Narrative
NATIONAL REQUIREMENTS				
Clostridium Difficile Infections (hospital associated)	Ceiling: 39	**13**	**Achieved/ Not Achieved**	Each reported C diff and MRSA bacteraemia infection case is formally reviewed by a collaborative Trust/CCG review panel. This panel then makes a recommendation on whether each reported case was due to a 'lapse in care' (e.g. avoidable) in the hospital environment. Both measures (cases and 'lapses in care') are monitored and reported up to Board level on at least a monthly basis. This will continue into 2018/19 and beyond. Root cause analysis methodology is used as the basis to identify risks and opportunities, and to ensure lessons are learned to drive continuous improvements in infection control.
MRSA Bacteraemia (hospital associated)	Zero Tolerance	**3**	**Achieved/ Not Achieved**	
All cancers, 31 day wait for second or subsequent treatment	Drugs treatments: 98% Surgery: 94% Radiotherapy: 94% Palliative Care: 94%	**100%** **100%** **100%** **100%**	**Achieved** **Achieved** **Achieved** **Achieved**	Improvements in collaboration with tertiary centres are taking place to ensure evidence of treatment is shared in a timely manner and that breaches are attributed fairly. The consolidation of local and national information systems is also evolving to support the robust, reliable and timely reporting of monthly and quarterly performance. There is continued focus on demand and capacity planning across all specialties and the transition to electronic referrals in progress. Enhanced internal predictive breach analysis and performance reports are being used to support performance management.
All cancers: 62-day wait for first treatment	GP referred: 85% NHS Screening: 90% Consultant upgrade: 85%	**88%** **90.82%** **100%**	**Achieved** **Achieved** **Achieved**	
All cancers: 2 week wait from referral to first appointment	All cancers: 93% Symptomatic breast: 93%	**95.93%** **96.38%**	**Achieved** **Achieved**	
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	92%	**90.7%**	**Not Achieved**	Increased emergency medical demand, particularly over the winter months, has impacted on the Trust's ability to meet this target. Nevertheless, concerted efforts were made throughout the year to improve performance. Digital management tools and reports are widely used on a daily basis to support the management of waiting times and inform scheduling and planning. Plans to improve performance within each service were reviewed and challenged on a weekly basis at executive level, with any deviations escalated appropriately as they arose.
Maximum wait of 4 hours in the Emergency Department from arrival to admission, transfer or discharge	95%	**91%***	**Not Achieved**	Although the Trust was successful in meeting this target on some months during the year, it was unable to sustain this performance throughout, particularly at times of significant pressure over the winter months. Maintaining an effective flow of patients through the hospital was a constant challenge, and collaborative work is continuing with local health and social care partners to help ensure the timely discharge of patients into more appropriate care settings. Similarly, the Trust continues to work with partners to identify and address any issues which may result in increased demand for services or longer stays in hospital.
ACUTE FOUNDATION TRUST TARGETS – MINIMUM STANDARDS				
Friends and Family Test (Patient Recommend Rate)	None	**93.6%**		The Trust evaluates and communicates quantitative and qualitative feedback from patients to continuously improve patient experience and service delivery. There is a continuing emphasis on increasing response rates to gain further insight into patient experience across all areas, including in the emergency department.
Complaints responded to within the required timeframe	90%	**87.1%**	**Not Achieved**	There is continued focus on the timely response to complaints and analysis of the nature of them to drive improvement in services and patient experience. Compliance with required response times for complaints is reported at Divisional meetings and to Trust Board.

*This figure represents the combined performance of the Trust's Type 1 and Type 3 units. Performance in 2017/18 of the Type 1 A&E department was 86.0%

1.2.3 Detailed Quality Performance Analysis

1.2.3.1 Referral to Treat (RTT)

Despite treating more patients than the previous year, the Trust has effectively maintained waiting times for planned elective patients at better than the NHS England aggregate performance.

Although the Trust did not meet the target to treat 92% of patients within 18 weeks consistently during the year, it maintained a level of performance above 90% until November 2017 when significant winter pressures meant that the Trust's focus, in common with most other organisations, turned to caring for the large number of very sick patients attending the Emergency Department. The Trust's performance was further hampered by the difficulties encountered in maintaining patient flow through the hospital. In particular, many patients who had been admitted with medical complaints had to be cared for in beds that would normally have been used for elective patients.

In spite of the decision made nationally to partially suspend elective care at the peak of the winter pressures, MKUH continued to treat as many patients as capacity allowed in order to minimise the extent to which their care was delayed.

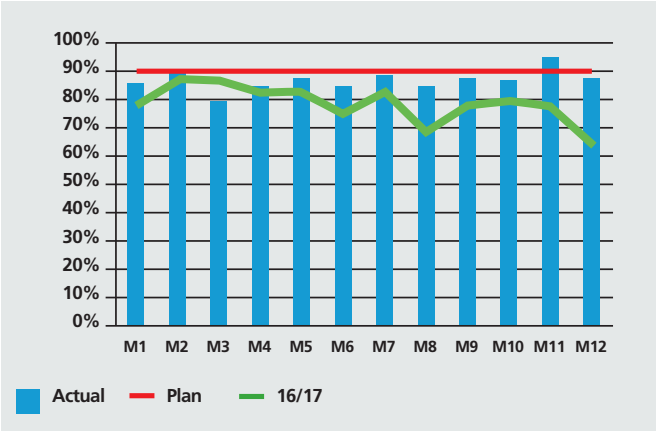
Month 2017/18	NHSI Trajectory	Trust Performance
April	92.2%	92.3%
May	92.3%	92.6%
June	92.3%	91.8%
July	92.2%	92.1%
August	92.1%	92.1%
September	92.1%	91.9%
October	92.2%	92.5%
November	92.2%	91.7%
December	92.0%	89.4%
January	92.1%	89.4%
February	92.0%	87.9%
March	92.0%	84.6%

1.2.3.2 Accident and Emergency 4 hour target

The Trust did not achieve the target of treating 95% of patients attending the Emergency Department within 4 hours. However its overall performance of 91% (all types) for the year placed it among the top performing trusts nationally on this measure. The Trust responded well to the added pressure on services during the winter months through effective activity planning involving the whole hospital, and coordinated with key partners across the local health economy. This meant that additional bed capacity was made available in advance of the coldest months. Clinical teams from across the organisation were deployed to provide assistance within the department at times of particularly high demand, and the Trust worked collaboratively with primary and social care to help free up capacity. Steps are being taken to build on the good practice developed in 2017/18 around speedier discharges and whole system working across Milton Keynes.

1.2.3.3 Response to Complaints

The Trust's target of responding to 90% of complaints within the agreed timescales was met in months 2 and 11 of the year. The overall performance has improved since the previous year following the recognition previously that there had not been sufficient involvement at divisional and clinical service unit level in complaint handling, and the provision of timely and satisfactory responses had not always been given the priority that it deserves. Complaints are now a key agenda item at divisional performance meetings and the Executive Management Board is sighted on those complaints that are out of time. Some divisions are now reporting significantly better performance, but the challenge to provide consistently timely responses across all divisions and services remains, especially at times when the Trust is experiencing significant operational pressures.



1.2.4 Development of the Business during the Year

The Trust has engaged fully as a partner within the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Partnership. This STP is one of eight that were selected nationally to work towards becoming an Integrated Care System. This is a system in which the respective NHS organisations (both commissioners and providers), in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. It is anticipated that they will provide joined up, better coordinated care. In return the organisations expect to have far more control and freedom over the total operation of the health system in the Bedfordshire and Milton Keynes area; and work closely with local government and other partners to keep people healthier for longer.

In addition to the collaboration with STP partners, the partnership between the Trust and the University of Buckingham Medical School continues with the opening in February 2018 of the new Academic Centre, which is located on the Trust site. First, second and third year students are now being taught in the Academic Centre and on the hospital's wards and clinical areas, with a range of Trust clinicians actively participating in their training.

The Trust has spent much of 2017/18 preparing for the implementation of its Electronic Patient Record (EPR) system, known as eCARE. The aim of this project is to better utilise technology to increase patient safety and clinical efficiency. It is expected that this system will revolutionise the way that care is provided across the hospital. An ambitious programme to train all clinical and support staff in the run up to the go-live date in May 2018 is in full swing.

During 2017/18, the Trust also applied for and was approved as a Fast Follower to the Global Digital Exemplar scheme. Global Digital Exemplars are internationally recognised NHS providers who are delivering exceptional care efficiently through the use of world-class digital technology and education. 26 Trusts were identified as exemplars, and MKUH is one of 17 acute providers given Fast Follower status, with West Suffolk NHS Foundation Trust identified as the Trust that we will be following. The funding that accompanies this opportunity is being used to make some necessary improvements to the Trust's IT capability, including providing some additional digital tools that will help maximise the operational capabilities of the eCARE system.

1.2.5 Impending Developments and Future Development Trends

The new university status of the hospital has provided a springboard for increasing research and development activity at the hospital. The Trust continues to work closely with a number of partners, including the Academic Health Sciences Network, University of Buckingham and the Open University on R&D opportunities.

In order to support developments at MKUH, the Trust Board at its meeting in February 2018 approved a new Estates Strategy, designed to build on the plans set out in the previous strategy, and support developments over the next five year period that will ensure that the Trust is able to meet the needs of the growing population of Milton Keynes and the surrounding areas. The highlights of current developments are as follows:

- Construction of the Academic Centre was completed in February 2018, and the building was formally opened by His Royal Highness the Duke of Kent on 20 February. The Centre provides facilities for use of the medical students being trained by Milton Keynes University Hospital in conjunction with the University of Buckingham, but will also provide a point of focus for development of the Trust's strategy around training and development.
- The Trust continues to repatriate cancer patients so that they can have their care closer to home. Plans for the building of a Cancer Centre on site are at an advanced stage, and it is expected that construction will commence in June 2018. Funding for this £15m project is being provided jointly by Milton Keynes Council and Macmillan Cancer Support, with the balance of £2.5m to be raised through charitable funding.
- The Trust's new main entrance was completed and opened in May 2017. This has become a focal point of entry to the hospital, and the enhanced retail facilities are very popular with patients and visitors.
- Given the growth in services and patient numbers, and the imminent start of building works for the Cancer Centre to the north of the site, the Trust and the local council have recognised that parking has become an issue on the site. Construction of an additional multi-storey car park to cater for increasing numbers of patients, visitors and staff commenced in February 2018, and is due for completion in April 2018.

1.2.6 Review of Financial Performance

Despite on-going financial pressures across the NHS, during 2017/18, the Trust continued its excellent track record of meeting or exceeding its agreed financial plan. In 2017/18 the Trust was set a financial control total deficit of £18.8m by NHS Improvement, against which it secured a lower (better) deficit of £16.1m (before revaluations). This represents a £5.0m improvement on the reported deficit of £21.1m in 2016/17.

During 2017/18 the Trust benefitted from £10.4m of income from the Sustainability and Transformation Fund for exceeding its financial control total and delivering against the Accident and Emergency 4-hour standard (£10.5m in 2016/17).

The Trust's income continued to grow over the course of 2017/18, with operating income from patient services increasing by £10.4m to £200.9m by the end of March 2018. This growth in income reflects the continued rise in demand for the hospital's services, with particular growth experienced in 2017/18 for the hospital's emergency services and a 5.9% increase in non-elective admissions during the year. Despite this significant increase in activity above planned levels, the Trust maintained or improved its performance on key indicators including accident and emergency and cancer waiting targets.

During 2017/18 the Trust continued to invest in the hospital's infrastructure through its capital programme. Significant investments in information technology as part of the Trust's eCARE programme, and enabling works to support an increase in the Trust's physical capacity, will enable the Trust to deliver more effective and efficient hospital services and allow for the significant growth in the population it serves. Total capital expenditure for the year was £16.8 million which was funded through a combination of internally generated sources, Public Dividend Capital and capital loans from the Department of Health and Social Care.

Statement of Comprehensive Income

As described above, the Trust experienced significant growth in the demand for its services in 2017/18, with activity volumes increasing by 5% on average. This increase in activity led to a £10.4m (5.5%) increase in income compared to the previous year. The main elements of the increase in clinical income were as follows:

- Non elective income: £9.0m (14.8%)
- A&E: £1.2m (10.2%)

Non-clinical income increased by £1.9m which was mainly as a result of increased student numbers for the training of doctors through the University of Buckingham Medical School.

Operating expenses increased by £7.8m (3.3%) on the previous year to £240.2m, £4.8m higher than the Trust's plan. This increase was largely due to higher activity volumes in year (particularly in respect of emergency activity) that required additional staffing (£2.5m) and increases to clinical supplies and services (£2.1m) in order to continue to provide safe and effective services. Operating expenses also increased due to a £1.8m increase in the premium payable to NHS Resolution for the Clinical Negligence Scheme for Trusts (CNST) and a £1.1m increase in education and training staff costs linked to the expansion of the University of Buckingham Medical School.

Statement of Cash Flows and Net Debt

As the Trust is in financial deficit, it is reliant on loan financing from the Department of Health and Social Care (DHSC) to meet its obligations as they fall due. In 2017/18, the Trust received a revenue loan from DHSC of £18.8m to fund the planned financial deficit, and a capital loan of £4.8m. The capital loan allowed the Trust to continue with the implementation of its electronic patient records system (eCARE).

The Trust ended the year with cash and cash equivalents of £2.5m which was in-line with its plan.

Total Assets Employed

Total assets employed decreased by £5.0m (7%) to £62.9m. This was largely due to the additional loans taken on by the Trust in the year which were only partly offset by higher non-current assets following an upwards revaluation of the Trust's estate.

£m	2016/17	2017/18
Non-Current Assets	182.3	166.4
Current Assets	29.0	26.7
Current Liabilities	(63.6)	(63.2)
Non-Current Liabilities	(84.7)	(62.0)
Total Net Assets Employed	62.9	67.9

Capital Expenditure

The Trust invested £16.8m in capital schemes during 2017/18. It received a loan of £4.8m from DHSC to continue its roll out of its electronic patient records system (eCARE). In addition DHSC funded £1.8m for investments in information and technology through the Global Digital Exemplar fund, and £1.0m to improve facilities to support primary care streaming. The Trust continued to maintain and replace existing equipment and buildings spending a further £9.2m on replacing essential equipment and maintaining the building and estate.

A further expansion of the capital programme is planned for 2018/19, and the Trust has already received approval for a DHSC loan to support its continuing eCARE programme, as well as funding to invest in its pharmacy services.

1.2.7 Counter Fraud

The Trust has an established counter-fraud policy to minimise the risk of fraud or corruption, together with a whistleblowing policy to be followed in the event of any suspected wrong-doing being reported. This policy also highlights the relevant provisions of the Bribery Act 2010, and the offences for which individual members of staff and the Trust corporately could be liable under this Act. The policy and related materials are available on the intranet and counter-fraud information is prominently displayed across the Trust's premises. The Trust's local counter fraud specialist (LCFS) reports to the Director of Finance and performs a programme of work designed to provide assurance to the Board in regard to fraud, bribery and corruption.

The LCFS attends audit committee meetings to present the programme and the results of counter-fraud work. The LCFS also gives regular fraud awareness sessions for Trust staff and investigates concerns reported by staff. Where these are substantiated, the Trust takes appropriate criminal, civil or disciplinary measures.

1.2.8 Statutory and Other Declarations

Compliance with HM Treasury Cost Allocation and Charging Guidance

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Cabinet Office public sector information guidance.

Political and Charitable Donations

There have been no political donations made by the Trust or charitable donations of the nature specified in the regulations made during the financial year. The Trust continues to benefit from charitable donations from its charity, Milton Keynes Hospital Charity, and is grateful for the efforts of fundraisers and members of the public for their continued support.

Better Payments Practice Code and Public Contracts Regulation

The Trust's policy is to pay its suppliers in accordance with its contractual terms and has, in the majority of cases, complied with the Better Payments Practice Code. It has maintained its high achievement of this with 91% of the all trade invoices for the year ending 31 March 2018 being paid within 30 days, (89% in 2016/17). This represented 93% of the value of invoices for the year ended 31 March 2018 (89% in 2016/17). The split between NHS and non-NHS invoiced is detailed in the tables below.

	For the Year Ended 31st March 2018			For the Year Ended 31st March 2017		
	Number of Invoices Paid within 30 days	Total Number of Invoices Paid	% Number paid within 30 days	Number of Invoices Paid within 30 days	Total Number of Invoices Paid	% Number paid within 30 days
NHS	1,325	1,986	67%	1,093	1,938	56%
Non NHS	69,061	75,470	92%	73,205	81,707	90%
Total	**70,386**	**77,456**	**91%**	**74,298**	**83,645**	**89%**
NHS	3,239,141	5,558,063	58%	4,496,061	6,488,872	69%
Non NHS	115,288,635	121,843,697	95%	105,829,854	117,624,843	90%
Total	**118,527,776**	**127,401,761**	**93%**	**110,325,915**	**124,113,715**	**89%**

The Trust did not pay any interest under the Late Payment of Commercial Debts (Interest) Act 1998; the requirements under Section 113(7) of the Public Contract Regulations are available on the Trust's website.

Accounting Policies and Other Retirement Benefits

The accounting policies for pensions and other retirement benefits are set out in accounting policies section of the Financial Statements and the arrangements for senior employees' remuneration can be found in the Remuneration report.

Board of Directors and Accounts Preparation

The annual report and accounts have been prepared under a direction issued by NHS Improvement. In support of the Chief Executive, as accounting officer of the Trust, the Board of Directors has responsibilities in the preparation of the accounts.

NHS improvement, with the approval of HM Treasury, in exercise of powers conferred on it by paragraph 25(1) of Schedule 7 of the National Health Service Act 2006 directs that the accounts give a fair and true view of the Foundation Trust's gains and losses, cash flows and financial state at the end of the financial period.

To this end, the Board of Directors are required to:

- apply on a consistent basis accounting policies laid down by NHS Improvement with approval of the Treasury
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts
- keep proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act
- safeguard the assets of the Trust and hence take reasonable steps for the prevention and detection of fraud and other irregularities

Income Disclosures Required by Section 43(2A) of the NHS Act 2006

Income disclosures are included in the notes to the accounts.

The Trust can confirm that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purpose. This is in accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

Critical Accounting Judgements

There are a range of judgements and estimates that have been made in the preparation of the annual accounts. These include the valuation of the Trust's estate and provisions for debt recovery. These judgements have been reviewed and are considered appropriate and in accordance with the appropriate accounting standards and further analysis can be found in the accounting policies section of the Financial Statements.

Audit disclosure

The Executive and Non-Executive Directors who held office at the date of the approval of the Directors' report confirm that, so far as they are aware, there is no relevant audit information of which the auditor is not aware. They also confirm that they each have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that Deloitte LLP is made aware of such information.


CareFusion

Statement on Report as Fair, Balanced and Understandable

The Board of Directors are responsible for preparing and agreeing the financial statements contained in the annual report and accounts. The Board confirms that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Enhanced Quality Governance Reporting

Arrangements for governing service quality are outlined in the Annual Governance Statement and the Quality Report, which is presented as part of this Annual Report.

The Trust continues to measure performance on a monthly basis and is taking additional actions where required, to ensure that it meets all of its mandated performance targets. Performance review meetings are held with the regional NHS Improvement Team every two months and updates are promptly provided in response to all queries raised about the Trust's performance.

There were no material inconsistencies between the Trust's assessment of key risks and either subsequent NHS Improvement ratings or Care Quality Commission assessments. The Trust Annual Governance Statement details how the Trust has reviewed and assessed the effectiveness of the Trust's systems of internal control.

Compliance with NHS Improvement Licence

In June 2017, NHS Improvement notified the Trust that it was no longer in breach of its Licence Conditions and issued a 'Discontinuation of Undertakings' notice which removed the conditions set out in in the 2014 and 2013 undertakings.

Outlook for 2018/19

Like other NHS organisations, the Trust faces the challenge of improving its financial performance whilst continuing to provide high quality services for a growing population. The Trust has been set a financial control total deficit for 2018/19 of £15.8m by its regulator, NHS Improvement, which has been accepted by the Trust's Board and is reflected in its annual plan. The Trust has set an efficiency programme target of £10.1m in 2018/19 which poses a significant challenge to the organisation, despite an excellent track record of delivering against financial targets in recent years.

The Trust will continue to work with its local partners, including those as part of the Bedfordshire, Luton and Milton Keynes STP, in order to continue to provide safe and effective care to the population it serves.

1.2.9 Environmental Sustainability

The Trust has started work during 2017/18 on its sustainable development plan, and it is expected that this will be rolled out during 2018/19. In the meantime, the organisation retains a commitment to sustainability and reducing its impact on the environment. The environmental impact of any development on the site is assessed as part of the business case process. One of the Trust's objectives is to develop as a good corporate citizen and this explicitly includes a commitment to reducing its environmental impact:

Objective 10 Develop as a Good Corporate Citizen	Key Deliverables
Reduce environmental impact through improved employee wellbeing Engage staff and patients to increase use of car share schemes, public transport and in reducing energy consumption Increase opportunities for staff to engage in recycling, energy saving initiatives and community project involvement Engaging staff to reduce food wastage	• Evidence engagement of and communication with staff around green travel options and energy usage with the aim to reduce parking on site and energy consumption, including encouraging uptake of the cycle to work scheme • Continually review transport services across the site as a critical strand of the estates development programme • Provision of recycling banks across the Trust, including clothes and textiles • Extension of existing furniture recycling programme • Review of food provision to ensure quality, healthy eating options and waste minimisation

In addition, the Trust is committed to reducing carbon emissions as part of the national sustainability agenda.

The following table shows Co2 performance per annum to date

2011/12	11,108 Tonnes
2012/13	11,183 Tonnes
2013/14	10,508 Tonnes
2014/15	9,786 Tonnes
2015/16	9,426 Tonnes
2016/17	9,660 Tonnes
2017/18	10,417 Tonnes

1.2.10 Social and Community Issues

At the last census collection (2013), the stated population for Milton Keynes was estimated to be 255,700, and in 2015, the Office of National Statistics estimated the population to have reached 261,750. By way of context, in 1967 Milton Keynes was designated as a new town, with the area having a population of 60,000. In particular, the last two decades has seen double digit growth; the historical trend between 2001 and 2013 showed a population increase of 43,000 - a growth of 20.2% compared with a growth rate of 8.9% for England during the same period. Milton Keynes was the 20th fastest growing local authority in England between 2005 and 2015 with a growth of 17.1 per cent.

The Population Bulletin 2013/14 outlined that the high population growth is expected to continue into the future and in addition there is anecdotal evidence which suggests that in all likelihood the population will increase at the same pace over the next decade. Current estimations suggest that the population of Milton Keynes will reach 308,500 by 2026. This is an increase of 46,750 people or 18 per cent between 2015 and 2026.

The two components of population growth are natural change and net migration; natural change refers to the difference between births and deaths and net migration refers to new residents arriving less any residents leaving the city. Natural change (difference between births and deaths) will add an average of 2,000 people to the population each year from 2015 to 2026. Net migration is the main driver of population growth peaking at 5,100 in 2019. This is driven by the planned house building to support migration from other parts of the UK.

The age profile of the Milton Keynes population is younger than that for England as a whole. 22.6% of the Milton Keynes population are aged under 16 compared with 19.0% in England. It is estimated that 25 to 64 year olds are projected to increase from 143,800 to 161,200, a rise of 12 per cent between 2015 and 2026. This age group represents the biggest proportion of all age groups throughout the years. 12.1% of the Milton Keynes population are aged 65+ compared with 17.3% in England. Looking forward, the 65 to 79 year olds are projected to increase from 25,600 to 36,900, a rise of 44 per cent between 2015 and 2026. Although this age group does not represent the highest proportion of the population, the percentage increase is significant and the associated rise in demand for healthcare services will be substantial.

The change in the age profile and population has by default resulted in a change in the ethnicity profile of the population. Between 2001 and 2011 the ethnic diversity (represented by those from an ethnic group other than “white” British) increased from 13.2% to 26.1%, compared to 20% in England. No data is currently available to provide a context to the change in ethnicity over the next 10 years, but if historical trends are to be taken into account, healthcare services will have to be been planned to reflect this change in ethnicity, with a particular focus in supporting prevention and promoting activities to support a focus towards the health and well-being agenda.

The change of ethnicity and the emergence of different cultural communities has resulted in the people of Milton Keynes holding a wide range of religious beliefs; 62.1% of people in Milton Keynes have a religious identity. Incorporating religious insights into the planning and the delivery of care can ensure services take seriously the values and beliefs. The Trust therefore recognises that pastoral and spiritual care is an integral part of any health needs assessment, and that these are best considered on an individual basis.

Disproportionate levels of population growth in Milton Keynes when compared to England have also resulted in significant pockets of deprivation and poverty. 18% of the child population live in low income families and furthermore there has been an 18% increase in children taken into care since 2012. The wards of Eaton Manor and Woughton are classed in the top 10% of most deprived wards in England when measured against the deprivation indicators of income, employment and education.

In addition to the population growth, the Trust has a catchment area which is wider than the boundaries of the Milton Keynes Unitary Authority, bringing in patients from part of Northamptonshire and the market towns of Buckingham and Leighton Buzzard. Furthermore, there is demand for healthcare services from employees of the large number of major organisations who commute from outside the Trust’s catchment area. The Trust is therefore actively working with its commissioners to address and meet the healthcare needs of all those currently using its services and those likely to do so in the future. A significant element of this work, in conjunction with other local health and care partners has involved a focus on developing plans to divert as many patients as possible away from the hospital setting. This will ultimately ensure that the Trust’s services are focused only on those patients who require such intervention, and that appropriate services are developed within the primary and community settings to support those patients who do not immediately need secondary services.

1.2.11 Human Rights issues

The Trust takes account of the provisions of the Human Rights Act 1998, insofar as they relate to the provision of healthcare, as well as the NHS Constitution. The Trust pays particular attention to the NHS' seven key principles. With regard to principle 1 (the NHS provides a comprehensive service available to all), the Trust ensures that its service provision is based entirely on clinical need and priority. The Trust has in place a Patient Access Policy, last updated in December 2016, which sets the standards to be followed in relation to waiting list management, and restates the commitment to a maximum of 18 weeks' waiting time from referral to the start of treatment. The Trust is also guided by principle 4 (the patient will be at the heart of everything the NHS does). In this regard, the Trust is in the process of consulting on a new Patient Experience Strategy to help ensure that patients' experience of accessing care at the Trust guides changes and improvements to service delivery. Feedback received via the various patient surveys and the Friends and Family Test also gives good indications of the level of patient satisfaction with the Trust's services.

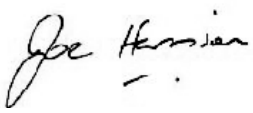
The Trust is cognisant of the human rights of both current and prospective members of staff in carrying out its work. The requirement within the Human Rights Act that there be no discrimination in the application of human rights on any ground informs the Trust's approach to engaging with its staff. For example, in 2017/18, a plan was put in place to help address the apparent disparity between the proportion of staff from a BME background in senior management roles, and the ethnic composition of the local area. The Trust also ensures that its suite of human resources policies reflects both the content and spirit of the Act.

1.2.12 Important Events Affecting the Trust since the end of the Financial Year

There are no significant events since the balance sheet date that are likely to have a material impact on either the Trust or the financial statements for the year ending 31 March, 2018.

1.2.13 Overseas Operations

The Trust has had no overseas operations in the reporting period.



Joe Harrison
CHIEF EXECUTIVE

Date: 25 May 2018

Section 2

Accountability Report

Accountability Report

2.1 DIRECTORS' REPORT

The directors are responsible for preparing the Annual Report and Accounts and consider the Annual Report and Accounts taken as a whole are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess Milton Keynes University Hospital's performance, business model and strategy.

Milton Keynes University Hospital Foundation Trust (the Trust) has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles set out in the 2012 version of the UK Corporate Governance Code.

The Board of Directors (the Board) consider the Trust to be compliant with the Code of Governance except as set out at page 90.

2.1.1 Composition of the Board of Directors

The Board of Directors comprises full-time executive and part-time non-executive directors. Executive directors are employees of the NHS Foundation Trust, led by the chief executive, and are responsible for the day-to-day management of the Trust.

Non-executive directors are not employees, but officers; they bring to the Board an independent perspective and it is their role to challenge decisions and proposals made by the executive directors, and to hold executive directors to account.

The role of the Board, led by the Chairman, is to provide effective and proactive leadership of the Trust; to set the strategic aims of the Trust, ensuring the quality, safety and effectiveness of the services provided and ensuring that the Trust is well-governed in every aspect of its activities.

The description of each of the current directors' areas of expertise and experience demonstrates the balance, completeness and relevance of the skills, knowledge and expertise that the directors bring to the Trust.

The composition of the Board of Directors at 31 March 2018 is detailed opposite:

NON EXECUTIVE DIRECTORS

Name	Appointment
Simon Lloyd	Chairman
Robert Green	Non-executive director
Tony Nolan	Non-executive director
Andrew Blakeman	Non-executive director
Parmjit Dhanda	Non-executive director
Helen Smart	Non-executive director (appointed 1 March 2018)
Heidi Travis	Non-executive director (appointed 1 March 2018)
John Clapham	Non-executive director (representing the University of Buckingham) (appointed 1 March 2018)

EXECUTIVE DIRECTORS

Name	Appointment
Joe Harrison	Chief Executive
Lisa Knight	Director of Patient Care and Chief Nurse
Ian Reckless	Medical Director
John Blakesley	Deputy Chief Executive
Ogechi Emeadi	Director of Workforce
Michael Keech	Director of Finance
Kate Jarman	Director of Corporate Affairs (non-voting)
Caroline Hutton	Director of Clinical Services
Emma Goddard	Director of Service Development (non-voting) (on secondment to the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Partnership from January 2017)

OTHER BOARD MEMBERS DURING 2016/17

Name	Appointment
David Moore	Non-executive director until February 2018

2.1.2 Biographies of Board Directors

Biographies for individuals who were serving as directors on the Board as at 31 March 2018 are detailed below. The Board of Directors is confident that it has within it the appropriate mix of skills and depth of experience to lead the Trust appropriately. The Board considers all the non-executive directors to be independent (with the exception of John Clapham) as they were appointed to their roles through open competition and are not employees of the Trust.

Simon Lloyd

CHAIRMAN

Simon joined the Trust in May 2015 for a three-year period. He originally qualified as a solicitor and spent some years in private practice as a corporate lawyer. He moved from private practice to work for Lloyds as an in-house lawyer before joining Bristol & West plc as Company Secretary. During his time at Bristol & West, Simon took on a number of functional responsibilities for the Bank of Ireland in the UK, including HR and Premises and Shared Services. Simon joined Alliance & Leicester in 2003 as Group Secretary and became Group Secretary and HR Director in 2007. Simon has held the roles of People & Talent Director, Chief People Officer & General Counsel and General Counsel & Chief Administrative Officer at Santander UK. He retired in December 2016.

Simon was appointed as Acting Chairman of the Trust in January 2017, following the sad passing of Baroness Margaret Wall. He was appointed to the role substantively following an open competition in November 2017.

Andrew Blakeman

NON-EXECUTIVE DIRECTOR
(SENIOR INDEPENDENT DIRECTOR FROM 1 MARCH 2018)
(CHAIR, QUALITY AND CLINICAL RISK COMMITTEE)

Andrew joined the Trust in February 2016 for a three-year period. He is a Chartered Accountant and has worked for BP for over 20 years in a variety of senior financial roles, most recently as Chief Financial Officer for BP's UK petrol station business. Andrew was a non-executive director on the board of NHS Blood & Transplant from 2008 to 2016 and was Chair of the Governance and Audit Committee, which covered audit, risk, quality and clinical governance. He also sits on the Quality and Clinical Governance Committee of Public Health England.

Robert Green

NON-EXECUTIVE DIRECTOR
(VICE-CHAIRMAN WITH EFFECT FROM 1 MARCH 2018)
(CHAIR, AUDIT COMMITTEE)

Robert joined the Trust in January 2013 on a four-year appointment. He was reappointed in February 2017 for a two-year term. He is a Chartered Accountant having trained with PwC. Robert has over 30 years board and senior financial experience mostly in the UK, but also in the Far East and US. He was Group Finance Director of Wilson Connolly, a FTSE 250 company based in Northampton. He has an MA in Mathematics from Oxford University and has lived in Milton Keynes for 16 years.

Tony Nolan

NON-EXECUTIVE DIRECTOR
(CHAIR, WORKFORCE AND DEVELOPMENT ASSURANCE COMMITTEE)

Tony joined the Trust in March 2014 on a four-year appointment. He has been reappointed for a further two years. Tony has held senior positions in a number of multi-national companies in the technology sector and is currently the Transformation Director for Arqiva, the UK's leading TV, radio and mobile infrastructure provider. He lives in Buckinghamshire.

Parmjit Dhanda

NON-EXECUTIVE DIRECTOR

Parmjit joined the Trust in February 2017 on a three-year appointment. He served as the Member of Parliament for Gloucester from 2001 to 2010, and was a Government Minister, covering the Young People and Families, Fire and Rescue Services and Community Cohesion portfolios. Parmjit has served as Non-Executive Director for an urban regeneration company and two Housing Associations. He is currently a Senior National Officer for the Prospect trade union. He lives in Buckinghamshire.

Helen Smart

NON-EXECUTIVE DIRECTOR

Helen joined the Trust in March 2018. A nurse and health visitor by background, she has worked across the NHS since 1986, and has held a variety of senior Executive roles, including Executive Director of Nursing and Operational Director for Learning Disability Services at Northamptonshire Healthcare Trust, Deputy Director of Commissioning for Primary Care at NHS Bedfordshire and Director of Community Services and Lead Nurse for South Essex Partnership University NHS Foundation Trust, a role she retired from in July 2017. Since then, Helen has been operating in an interim consultancy capacity, working with the North Central London STP as Programme Director for the Care Closer to Home programme across five CCGs, and is currently at Hertfordshire Partnership Foundation Trust. She has also worked for the Department of Health, and in advisory roles for the CQC and at a Governmental level. She lives in South Northamptonshire.

Heidi Travis

NON-EXECUTIVE DIRECTOR
(CHAIR, FINANCE AND INVESTMENT COMMITTEE)

Heidi joined the Trust in March 2018. She joined Sue Ryder in March 2010 as Director of Retail, and took on the role of Chief Executive in September 2013. Previously, Heidi had worked as a business consultant developing small businesses. Before that, she spent 25 years at Marks & Spencer, most recently as an executive in group planning and strategy as well as managing a buying group. Heidi also worked as a lay member of the Aylesbury Vale CCG until 2013. She became a non-executive director for Bucks PCT (now Bucks NHS) in 2008 and chairs a Bucks speech and language therapy group. She lives in Milton Keynes.

John Clapham

NON-EXECUTIVE DIRECTOR

John is a Pro Vice Chancellor of the University of Buckingham, and he represents the university on the MKUH Board. He has a background of working in the higher education industry and in biomedical research within the pharmaceutical industry. One of the founder team of the University of Buckingham Medical School, he has expertise in project management, pharmaceutical research, biomarkers, molecular biology, biotechnology, and people management. He is a strong research professional with a PhD focused on Biochemistry and Molecular Biology from Birkbeck College, University of London.

Executive Directors

Joe Harrison

CHIEF EXECUTIVE

Joe joined the Trust as chief executive in February 2013. He was formerly chief executive at Bedford Hospital, and has 25 years' experience of working in the acute sector of the NHS, covering both big teaching hospitals and district general hospitals. His roles have included a range of senior operational and corporate positions at several London hospitals, and he has a track record of improving patient services and performance.

John Blakesley

DEPUTY CHIEF EXECUTIVE

John has over 30 years' experience in the NHS. His career started in pathology, before moving into general management. He has undertaken a range of executive director roles as director of performance and delivery and deputy chief executive as well as director of market management (commissioning for a large PCT). In addition, John has experience of the commercial sector with a specialised surgical company. He has a particular interest in using information systems to improve patient care and decision-making.

Kate Jarman

DIRECTOR OF CORPORATE AFFAIRS

Kate has substantial experience as a communications professional and company secretary, and has worked on and with boards in the acute health sector and police and criminal justice agencies. Before joining Milton Keynes University Hospital as director of corporate affairs with responsibility for integrated governance and assurance, membership and corporate communications, Kate spent a number of years at Bedford Hospital, latterly as associate director of corporate affairs and communications and company secretary. Kate is passionate about staff and patient engagement, leadership, culture and about developing integrated governance systems to support the delivery of safe, effective, high quality care.

Michael Keech

DIRECTOR OF FINANCE

Mike qualified as a Chartered Accountant (ACA) and is a member of the Institute of Chartered Accountants in England and Wales (ICAEW). He has significant experience of NHS finances, having started his career as an external auditor of NHS foundation trusts before taking on a range of finance and strategy roles at the healthcare regulator NHS Improvement (previously Monitor). Prior to arriving at the Trust he was heavily involved in supporting challenged health economies in developing plans to return to a sustainable position. His roles have included leading on the financial analysis for a Sustainability and Transformation Plan (STP) footprint and supporting NHS Improvement's work in a number of high profile organisations.

Ogechi Emeadi

DIRECTOR OF WORKFORCE

Before joining the Trust in March 2014, Ogechi was Deputy Director of Human Resources at North Middlesex University Hospital. She has over 20 years' experience working in HR in the NHS, during which time she has delivered on strategic and operational human resources initiatives and on the organisational development agenda. Ogechi is passionate about improving staff health and wellbeing and driving forward staff development.

Caroline Hutton

DIRECTOR OF CLINICAL SERVICES

Caroline joined the Trust in 2013 to lead on transformation, and was appointed substantively to the role of director of clinical services, responsible for operational management, in October 2014. She is a registered nurse with 29 years' NHS experience, and has held a number of senior positions both operationally and clinically, working across all healthcare sectors, including the leadership and delivery of complex cross-organisational projects and programmes. Caroline has significant experience of working in partnership with private sector organisations and commercial and legal teams from her leadership positions with the National Programme for IT, and is passionate about encouraging collaborative teamwork with a view to introducing new approaches to the delivery of patient care, as well as encouraging a data driven approach to operational planning and delivery.

Emma Goddard

DIRECTOR OF SERVICE DEVELOPMENT
(ON SECONDMENT TO THE BLMK STP FROM NOVEMBER 2016)

Emma was appointed in December 2014 as director of service development. She has held various senior operational posts across a number of NHS hospitals, and has significant experience of clinical services within the acute sector, and partnership working with commissioners, primary care services and the private sector. Prior to joining Milton Keynes University Hospital, Emma spent some years working as chief operating officer at Bedford Hospital. She also spent some time working as interim director of operational performance, responsible for the day to day running of the sites and supporting the Foundation Trust applications at Hillingdon Hospitals.

Lisa Knight

CHIEF NURSE AND DIRECTOR OF PATIENT CARE

Lisa was appointed as chief nurse and director of patient care in October 2012. She brought a wealth of experience gained from a range of nursing disciplines. Having trained and spent the first few years of her career at hospitals in north London, Lisa spent a year at an acute medical oncology unit in Toronto. On her return to the UK, Lisa pursued her interest in burns and plastic surgery care, working in units at University College Hospital and the Royal Free Hospital, utilising her postgraduate diploma in this specialty. She worked as operations manager for surgery at Chase Farm Hospital, covering anaesthetics, operating theatres and intensive care. This was followed by roles at North Middlesex as senior nurse for A&E and medicine; interim deputy chief nurse at Epsom and St Helier; and interim chief nurse at Addenbrooke's. Her particular nursing interests include developing effective pathways for the care of the elderly, safeguarding adults and managing the needs of patients with dementia.

Dr Ian Reckless

MEDICAL DIRECTOR

Ian was appointed as Medical Director in April 2016. He trained at St George's Hospital Medical School, London and undertook postgraduate training in the Oxford area. Ian worked as Special Adviser to the Healthcare Commission in 2004, and was Special Assistant to the Chief Medical Officer in 2005/06. He was appointed Consultant Physician and Senior NIHR Research Fellow at the Oxford Radcliffe Hospitals NHS Trust, and he later held the roles of Associate Medical Director (Quality) and Clinical Director, Neurosciences at the successor Oxford University Hospitals NHS Foundation Trust. He continues to undertake clinical work both at Milton Keynes and in Oxford, where he remains Honorary Consultant Stroke Physician / Senior Clinical Lecturer at the John Radcliffe Hospital. He also contributes to the work of the Isle of Wight Clinical Commissioning Group as secondary care doctor on the Governing Body. Ian has a particular interest in postgraduate education, having previously served as Training Programme Director, and has authored books on general medicine, and the interface between medicine and the law.

Members of the Board who also served in 2017/18

David Moore

(NON-EXECUTIVE DIRECTOR UNTIL FEBRUARY 2018)

David joined the Trust in March 2012, initially on a four year appointment which ended in February 2016. He was subsequently reappointed for a further two year term, and this second and final term ended in February 2018. David spent 28 years working internationally for Citibank, returning to the UK in 2008 as Managing Director for Citi Private Bank Operations Division in EMEA and Asia before returning at the end of 2011. David has significant experience in governance, finance, operations, strategic planning, quality and change management. He was a public member of Network Rail from 2008 to 2011 and Lay Member of the University of Leicester, sitting on their Finance, Remuneration and Health & Safety Committees. He was also Independent Auditor for the Welton Townlands Trust.

2.1.3 Balance of Board Members and Independence

At the end of the financial year 2017/2018, the Board of Directors comprised:

- Chairman of the Trust
- Seven further non-executive directors
- The chief executive
- Five further Executive directors
- Three non-voting directors (one who has been on secondment out of the Trust for the duration of the reporting period)

As of 31 March 2018, 44% of the Board of Directors were female (there were seven female and nine male Board members). The Board of Directors reviewed and confirmed the independence of all the non-executive directors (with the exception of John Clapham who represents the University of Buckingham) who served during the financial year 2017/18.

The Board of Directors also considers that the balance of skills and experience of its members is complete and appropriate to address the operational and economic challenges the Trust expects to face over the next few years.

2.1.4 Non-Executive Director Appointments

In February 2018, the second term of office of David Moore came to an end. All non-executive directors are eligible to serve two terms of office, provided that their maximum tenure does not exceed six years, and Mr Moore has therefore left the Board. Another vacancy had been created by Simon Lloyd's substantive appointment as Chairman.

The appointment of non-executive directors of the Trust is the responsibility of the Council of Governors. A Non-Executive Appointments Committee of the Council has been established, and for the purposes of the exercise to fill these vacancies its membership comprised of:

- Liz Wogan (lead governor, publicly elected) (Chair)
- Alan Hastings (publicly elected)
- Andrew Buckley (appointed, Milton Keynes Council representative)
- Peter Skingley (publicly elected)

The Committee agreed that in order to maintain an appropriate balance of skills within the Board, one of the new non-executive directors would be a clinician by background, while the other would have relevant financial skills.

Recruitment consultants were engaged to support the appointment exercise. 38 applications were received in total, 16 for the finance role and 12 for the clinical. Three candidates for each role were eventually selected for interview. Interviews took place on 13 February 2018, and were supplemented in relation to the clinical candidates by peer group discussions held with other members of the Council of Governors and some of the executive directors. The interview panel comprised of the Non-Executive Appointments Committee, as well as Simon Lloyd, the Chairman of the Trust, and an independent assessor, Hattie Llewellyn-Jones (chair of Buckinghamshire Healthcare NHS Trust). The trust secretary provided support to the panel.

Following this process, the Non-Executive Appointments Committee recommended to the Council of Governors that Helen Smart and Heidi Travis be appointed to the clinical and finance non-executive director roles respectively. This recommendation was accepted and both appointments took effect from 1 March 2018.

During March 2018, the Chairman recommended to the Council of Governors that Tony Nolan whose first four year term of office ended in that month be reappointed to the Board for two years. The Council of Governors were cognisant of the guidance set out in the NHS Foundation Trust Code of Governance as below:

> "B.7.1. In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role."

This recommendation was accepted.

A non-executive director may resign from their role by giving the agreed period of notice in writing to the Chairman and the Council of Governors, and the Chairman may resign by giving notice to the Council of Governors. In addition, the Chairman or any non-executive director may be removed from office on the approval of three quarters of the members of the Council of Governors.

2.1.5 Board, Board-level Committee and Directors' Performance and Effectiveness Review

The Board of Directors meets regularly and has a formal schedule of matters specifically reserved for its decision. This includes high-level items relating to the Trust's strategy and how this is operationalised, its business plans and budgets, regulations and control, and the annual report and accounts. The Board delegates other matters to the executive directors and senior management as appropriate.

Meetings of the Board of Directors follow a formal agenda, which includes reports and updates on operational performance and against quality indicators set by the Care Quality Commission (CQC), NHS Improvement and by management, strategic issues, financial performance, and clinical governance. The performance measures include the amount of time that patients are required to wait to be treated at the emergency department, lengths of stay, the effectiveness of processes for infection control, patient experience measures, including the timeliness within which complaints are handled, and the results of the Friends and Family Test. The Board also benchmarks its performance against that of other Trusts of a similar size and configuration.

The executive and non-executive Directors recognise the importance of evaluating the performance and effectiveness of the Board of Directors as a whole, the sub-committees of the Board of Directors, and of individual directors. The performance of individual directors is assessed over the course of the year in terms of:

- Attendance at Board and Board committee meetings,
- The independence of individual non-executive directors,
- The effectiveness of the contributions of each executive and non-executive director to the business of the Board and its committees, both in and out of meetings,
- The Board's effectiveness in providing a strategic direction to the Trust and its ability to provide the lead requisite leadership.

In respect of individual appraisals:

- The Chairman undertakes the appraisal of the chief executive and non-executive directors;
- The Chief Executive undertakes the appraisal of the executive directors;
- The Senior Independent Director undertakes the appraisal of the chairman, having sought feedback from the rest of the Board of Directors, the Trust Secretary and from the Governors and key stakeholders
- The Chief Executive discusses and reviews the executive directors' appraisals with the Chairman and the Remuneration Committee.

The process for the appraisal of the chairman and the non-executive directors has been approved by the Council of Governors. Governors evaluate the performance of the Board of Directors as a whole in terms of meeting its targets and communicating with its staff, members and stakeholders.

The result of the evaluation process of the Board of Directors' performance in respect of the year ended 31 March 2018 was that the Board collectively and the directors individually were deemed to have performed well. Evaluation of the committees indicates that they are working well, and the appointment of a new Chair to the Quality and Clinical Risk Committee in particular has led to a refresh of that Committee's approach to assuring the quality of the services that the Trust provides. Improvements made to the overall quality of information provided have led to richer and more in-depth discussions on the key issues, and a greater level of assurance to the committees and the Board.

The Board of Directors ensures that the principles set out in the Well-Led Framework not only inform their work, but are also embedded across the organisation. For example, the Board receives regular reports on all aspects Trust performance, and ensures that these address each of the eight Key lines of Enquiry as set out in the Framework. Further detail about the Trust's approach to ensure that its services are Well-Led is set out in the Annual Governance Statement later on in this report.

2.1.6 Attendance at Board Meetings

	Board of Directors 12	Audit Committee 5	Charitable funds Committee 3	Finance & Investment Committee 10	Quality & Clinical Risk Committee 5	Remuneration Committee 3	Workforce Development Assurance Committee 4	Council of Governors 6
Andrew Blakeman	10	5			5	3	4	3
John Blakesley	10	4		5				3
John Clapham (from March 2018)	1							
Parmjit Dhanda	11				5	3		3
Ogechi Emeadi	12			1			4	1
Emma Goddard*								
Robert Green	12	5	3		1	2		4
Joe Harrison	10			5	1	3		4
Caroline Hutton	8			4				2
Kate Jarman (formerly Burke)	9	4	3		2			1
Mike Keech	12	5	3	10				3
Lisa Knight	10				4			3
Simon Lloyd	12			8	1	3	2	4
David Moore (until February 2018)	11		2	9	4	2		4
Tony Nolan	11			8		3	4	2
Ian Reckless	12			3	5			3
Helen Smart (from March 2018)	1				1			1
Heidi Travis (from March 2018)	1							1

*On secondment to BLMK STP from November 2017. There is no expectation that Emma Goddard will attend any MKUH board or committee meetings during the course of this secondment.

2.1.7 Detail of Company Directorships and Other Significant Interests Held by Directors or Governors

Members of the Board of Directors and the Council of Governors did not hold any other non-executive directorships or commitments that are disclosable under the Monitor Code of Governance.

2.1.8 Board Register of Interests

The Trust maintains two registers of interests. The first includes interests of all directors; the second interests of the Council of Governors. Both documents are available for public inspection by making contact with the Trust secretary by email at adewale.kadiri@mkuh.nhs.uk.

An annual report is made to the Trust Board regarding the interests of executive directors and non-executive directors. In addition, executive and non-executive directors are required to declare any potential conflict of interest that they may have in respect of any item on a Trust Board or Board Committee agenda. In the event that it is decided either by the Trust chairman or the chair of the committee that a conflict does in fact exist, the Board or committee member would be instructed to excuse themselves from the discussion of that particular item.

2.1.9 Audit Committee

The Audit Committee's key role is to ensure that the Trust has an adequate and effective system of internal controls. The Committee focuses on the establishment and maintenance of controls that are designed to give the Board reasonable assurance that the Trust's resources are safeguarded, waste and inefficiency limited, and that reliable information is produced to demonstrate that value for money is constantly sought.

The key responsibilities delegated by the Board to the Committee are to:

- Ensure the effectiveness of the organisation's governance, risk management and internal control systems,
- Ensure the integrity of the Trust's financial statements, the Trust's Annual Report and in particular the Annual Governance Statement, and
- Monitor the work of internal and external audit and ensure that any actions arising from their work are completed satisfactorily.

The Audit Committee is chaired by Robert Green, a non-executive director of the Trust. As set out above, Mr Green has relevant financial experience, and therefore has the skills and knowledge to effectively perform this role. During the course of 2017/18, the other permanent member of the Committee was Andrew Blakeman. The Committee met five times during 2017/18, and at each meeting it considered: the work of the internal audit function, the work of the external auditors, including the framework within which they conduct the audit of the Trust's financial statements and its Quality Report indicators, and any issues that they wish to raise both in the course of the audits and following the conclusion of their work. The Committee also considered the work of the Trust's counter-fraud team, taking account of fraud trends that the Trust needs to be aware of, and steps being taken to raise fraud awareness across the Trust. The Committee also considers a list of all debts that are to be written off; updates to the IFRS and accounting policies, and the Trust's overall approach to risk management, including consideration of the board assurance framework and corporate risk register.

During the course of the year, the Audit Committee reviewed reporting against key national and regulatory standards. It agreed the internal audit annual work plan, and received draft and final reports of their reviews, including reviewing management responses, and assessing progress against recommendations made. With regard to the external audit function, the Committee agreed with the external auditor the nature and scope of the of the audit as set out in their annual plan, discussed the auditors' evaluation of the audit risks and assessment of the Trust, and the impact of this on the audit fee set.

The Committee also reviewed other work carried out by the external auditors, and in 2017/18, this focused mainly on progress made by management in addressing recommendations, principally relating to historic but continuing concerns relating the quality of the data generated through and relating to key aspects of the Trust's operations. These concerns were initially brought to light through the audit of the Trust's 2015/16 quality report.

In June 2017, concerns about the inaccuracy of Referral to Treatment (RTT) counting, and the recording of pathway clock stops were conveyed to NHS Improvement (NHSI) via a whistle blowing disclosure. The disclosure alleged inappropriate removal of patients from the Trust's Patient Tracking List following a change in practice in July 2016. As a result, NHSI conducted a review in July covering a sample of Trust RTT data from 2016/17. The NHSI review found no evidence that the Trust had changed its procedures during the course of the year to improve its RTT performance position as the whistle blower had alleged, but a number of recommendations to improve the management of RTT were made, echoing some of the external auditor's findings in the course of their testing of the Quality Report. The Audit Committee continues to monitor management progress on addressing the issues raised by both internal and external audit, and NHSI. A follow-up visit was undertaken by NHSI in March 2018, to assess progress against recommendations, with very positive feedback on progress made.

The Audit Committee also receives and interrogates reports and updates from the Trust's counter-fraud providers. In 2017/18, the Trust's approach to ensuring that the Trust recovers payment from overseas patients who are not entitled to free care continued to be an area of focus, as well as increasing levels of fraud awareness among all staff.

The Audit Committee has been assured by the Head of Internal Audit Opinion on the Trust's internal control environment and approach to identifying, assessment and mitigation planning to risks. This was supported by in year and year end reviews, and subject to submission to the Audit Committee on 25 May 2018.

The Audit Committee reviews auditor independence both as part of its scrutiny of the annual report and accounts, and as part of its annual review of the auditors' work. The Committee has also engaged regularly with the external auditors throughout the year, including in private session. The Committee is satisfied that to the best of its knowledge, there are no issues that compromise the external auditors' independence. The Chair of the Committee regularly discusses the effectiveness of both internal and external auditors with the Director of Finance.

Deloitte have provided external audit services to the Trust since April 2012 on a five-year contract. In December 2016, the Council of Governors commenced the process, through an open procurement competition, of appointing new auditors. In May 2017, the Council of Governors agreed that Deloitte would be reappointed as the Trust's external auditors with effect from July 2017.

For the 2017/18 audit, the Trust incurred statutory audit fees of £69,622 (excluding VAT) and an additional fee of £5000 (excluding VAT) for the quality accounts limited assurance work. No additional auditor remuneration was incurred during the year.

The following steps were taken during 2017/18 to ensure that auditor objectivity and independence is safeguarded:

- At each meeting of the Audit Committee attended by the external auditors they were asked to declare any interests that they may have in any of the items on the agenda. No such declarations were made.
- The external auditors have confirmed their compliance with the APB Ethical Standards for Auditors, and do not consider that their professional judgement or objectivity has been compromised.
- The Trust and the auditors ensured that fees for the provision of non-audit services by the external auditors did not exceed 70% of the audit fee, as mandated by the updated Auditor Guidance Note 1 issued in December 2016. The external auditors also did not perform any of the prohibited non-audit services set out in the guidance note. Details of the fees that were charged for non-audit work have been disclosed in the external auditors' report, and no further fees were charged.
- The external auditors have continued throughout the year to review their independence and ensure that appropriate safeguards are in place. These include the rotation of senior partners and professional staff, and the involvement of additional partners and professional staff to carry out reviews of the work performed and to advise as necessary.

2.1.10 Remuneration Committee

The Remuneration Committee is a sub-committee of the Trust Board. It is chaired by the Trust Chairman and comprises all the non-executive directors. The Committee meets as required, but its terms of reference recommend that this should be at least twice a year. Its main role is to agree the salaries and remuneration packages of the chief executive and the executive directors. The chief executive and the director of workforce attend the meeting, but leave when discussions about their own positions are to be held.

The Remuneration Committee met on three occasions in 2017/18.

2.1.11 Council of Governors

The Council of Governors is responsible for representing the interests of NHS Foundation Trust members, public, staff and together with partner organisations of the trust, shares information about key decisions with the membership.

The Board of Directors reports to the Council of Governors on the performance of the Trust and its progress against agreed strategic and corporate objectives, and consults on its future direction. In particular, the Council of Governors holds the non-executive directors on the Board to account.

Governors report matters of concern or interest raised at their local health events or constituency meetings to their counterparts and to the directors. Members of the public are given the opportunity to ask questions addressed to the Governors, directors or any other staff members in attendance at the local health events or Council of Governor meetings.

All non-executive and a number of executive directors are asked to attend the Council of Governors' meetings in order to gain an understanding of the views of the Trust's Governors and Members. Other staff may also attend to provide assurance or to report on progress of any matters of interest.

Developing effective relationships with the non-executive directors has been a key priority in 2017/18 and a range of new opportunities has been introduced for Governors to meet with and hold the NEDs to account. The Council of Governors has met jointly with the non-executive directors during the year and regular informal meetings are taking place.

The Council of Governors is responsible for non-executive director appointments, and during 2017/18 they appointed the Chairman and three new Non-Executive Directors. Governors were also actively involved in the tender process for the appointment of the Trust's External Auditors. The final appointment was made at a public meeting of the Council of Governors in May 2017.

The Council of Governors also contributed to and gave initial approval for a number of changes to the Trust's Constitution. Final approval was subsequently given at the Annual Members' Meeting held in September 2017.

To enable the Council of Governors to exercise their statutory duties, the Board of Directors ensures that the Council receives the Annual Report and Accounts, is consulted on the content of the Quality Account and is presented with other management reports detailing Trust performance in all areas. Presentation of the 2016/17 Annual Report and Accounts took place at the Council of Governors' meeting in July 2017.

During the course of 2017/18, the Council of Governors took advantage of a number of formal and informal opportunities to engage with the Trust membership, with a view to seeking their views on the Trust's performance, plans and priorities. For example in September 2017, a number of governors attended a Healthwatch Milton Keynes organised event at the centre:MK at which they engaged with and signed up prospective members of the Trust. The Governors interface with consultative forums such as the Patient Participation Groups (PPGs) has also provided patient and local community feedback to the Board of Directors. A successful Meet the Members event was held in May 2017 at which members of the public were invited to hear about the Trust's joint medical school venture with the University of Buckingham and the education and training facilities available.

In August 2017, Governors were able to engage with those in attendance at The MK Play day event in Campbell Park which provided free, fun accessible activities for all children, young people and their families from across Milton Keynes.

Feedback received by Governors from these and other interactions with Trust members and the public was reflected in their comments on the Trust's Annual Plan and the Patient Experience Strategy.

2.2.1 Membership of the Council of Governors

The Council of Governors is chaired by the Trust chairman. It consists of 15 governors elected by public members of the Trust (two vacant at 31 March 2018), each representing a geographic constituency, seven governors elected by staff of the Trust (one vacant as at 31 March 2018), and six appointed governors (two from Milton Keynes Youth Cabinet) one vacant as at 31 March 2018.

The table at Appendix 2 lists the governors and their attendance record at the six Public Council of Governors meetings that took place in the year.

In light of its status as a University Trust, the Constitution has been updated to allow for a representative from the University of Buckingham to join the Council of Governors as an appointed governor. Discussions about this are being held with the university.

2.2.2 Register of Governors' Interests

A register of governors' interests is maintained by Milton Keynes University Hospital NHS Foundation Trust. A copy of the latest version submitted to the Council of Governors may be inspected during normal office hours at the Trust Secretary's office.

2.2.3 Lead Governor

The publicly-elected Governors select amongst themselves one Governor to be the Lead Governor of the Council of Governors. The Lead Governor coordinates any communication that might, in extreme circumstances, be necessary between NHS Improvement (the independent regulator) and the other Governors, and acts as a main point of contact for the Chairman and the Senior Independent Director. Throughout the year ending 31 March 2018 the lead governor role was held by Lesley Sutton followed by Liz Wogan.

2.2.4 Elections

In 2017/18 elections were held for the following seats on the Council of Governors.

Date	Constituency (see Appendix 1 for key)	Result
August 2017	Appointed Governor: Community Action:MK	Clare Walton (appointed)
October 2017	PUBLIC: Emerson Valley, Furzton, Loughton Park.	William Butler (elected)
October 2017	PUBLIC: Linford South, Bradwell and Campbell Park	Amanda Jopson (elected)
March 2018	PUBLIC: Emerson Valley, Furzton, Loughton Park.	Douglas Campbell (elected)
March 2018	PUBLIC: Linford South, Bradwell and Campbell Park	Akin Soetan (unopposed)
March 2018	PUBLIC: Outer Catchment area including Buckingham, Winslow, Leighton Buzzard, Linslade, Newton Longville, Deanshanger.	Amanda Anderson (elected)
March 2018	STAFF: Non Clinical (Admin & Clerical, Estates, Finance. HR, Management).	Marc Yerrell (elected)

The Trust commissioned the services of UK Engage to undertake the election process. The literature produced by UK Engage is very user friendly and easy to complete with the added opportunity of online participation which has again proved to be very popular. In 2017/18 there was a continued increase in the number of contested elections and overall turnout.


Welcome To
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2.2.5 Governor Development

Milton Keynes University Hospital NHS Foundation Trust is committed to providing support for Governors to carry out their role effectively and in November 2017, a bespoke event for newly appointed Governors and a refresher for all Governors was introduced and provided by NHS Providers, GovernWell who provide the national training programme to equip all NHS Foundation Trust Governors with the skills required to undertake their role.

The format of the Council of Governors meetings has continued to develop and includes presentations on key issues and developments within the Trust. There has also been increased prominence of Non-Executive Directors at The Council of Governors' Meetings and the introduction of the Governor Patient Story, which has helped to improve the Governors' understanding of their role and their knowledge on subjects that are relevant to the Trust and the NHS.

To give more governors the opportunity to develop their skills and knowledge, a rotational lead governor model has been adopted. This model, which is supported by GovernWell, provides Governors with leadership and development opportunities and supports succession planning within the Council. It also provides governors with the opportunity to 'test' whether the role is suitable for them, and the relatively short duration of each tenure means that the commitment is not onerous. Three Governors who expressed interest have each undertaken the role for a specified period of time until the model was reviewed in November 2017.

In 2017/18, further opportunities to support governor involvement and development included activities such as the involvement in work programme issue specific groups such as development of the hospital estate and consultation events.

Governors are encouraged to attend external events and the attendee prepares a summary of the learning and presents it to the Council of Governors.

The Engagement Group, which meets between Council of Governors meetings is chaired by a public governor. The Engagement Group is responsible for the Membership and Engagement Strategy which was refreshed for implementation in 2017/18. Sub groups where appropriate are held in order to provide focus to a particular issue.

Governors have been or are currently involved in various working groups and committees, these include: the Engagement Group; Non-Executive Appointments Committee; The Quality and Clinical Risk Committee, The Charitable Funds Committee, The PLACE inspection team; The 15 Steps initiative which evaluates the environment of hospital areas from the patient's perspective on the first 15 steps made; The Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP) forum meetings; the new main entrance consultation group and the North Site Development Operational Group.

2.2.6 Attendance at Council of Governor Meetings

The Council of Governors has met formally six times during the year, (seven including the Annual Members' Meeting). The Trust's Constitution requires the Council of Governors to meet at least three times a year. The Council of Governors, after each of their meetings, provide a report to the Board to ensure all key issues discussed are brought to the Board's attention formally. Details of governors' attendance at the six Council of Governors meetings held in 2016/17 are included in Appendix 2.

2.3 Membership

Milton Keynes University Hospital NHS Foundation Trust is committed to establishing and growing an effective membership and during 2017/18, a number of additional steps have been taken to improve engagement and increase membership.

In 2017/18 extensive work has continued to secure our membership community by addressing natural attrition and increasing the demographic diversity of Trust membership. We have adjusted our database to better reflect the true number of eligible staff members. This has enabled efficient, effective communication to be made in the most convenient way to members and broadened the involvement of the public membership.

In 2017/18 initiatives that proved popular for members were The Meet the Members events and the 'Members' News' a free newsletter, providing up to date developments and news about the hospital, information and dates for diaries of meetings and events.

2.3.1 Number and Analysis of Members

	2016/17	2017/18
PUBLIC CONSTITUENCY		
At year start 1 April	5,673	**5,536**
New members	154	**101**
Members leaving	291	**87**
At year end 31 March	5,536	**5,550**
STAFF CONSTITUENCY		
At year start (1 April)	4,050	**2,821**
At year end (31 March)	2,821	**2927**
PUBLIC CONSTITUENCY AGE (YEARS)		
0-16	2	**1**
17-21	44	**46**
22+	2,060	**2101**
Not declared	3,430	**3402**
PUBLIC CONSTITUENCY ETHNICITY		
White	4,354	**4350**
Mixed	93	**94**
Asian or Asian British	345	**374**
Black or Black British	240	**247**
Other	69	**52**
Not declared	436	**433**
PUBLIC CONSTITUENCY GENDER		
Male	2,178	**2180**
Female	3,358	**3370**

2.3.2 Membership Constituencies

The trust has staff and public constituencies, and also has appointed governors representing local stakeholders in partnership constituencies. Within the terms of the Constitution, all staff are automatically members unless they decide to opt out of membership, providing they have been appointed to a post for a minimum period of twelve months. Members of the public living within the Trust's catchment area who are over the age of 14 and not employed by the Trust are entitled to become public members. To be a representative on the Council of Governors, applicants should be aged 16 years or over.

The areas of the public constituency and the number of current members are shown below:

PUBLIC CONSTITUENCIES	MEMBERSHIP
Bletchley and Fenny Stratford, Denbigh, Eaton Manor and Whaddon	1,115
Emerson Valley, Furzton, Loughton Park	800
Linford South, Bradwell, Campbell Park	81
Hanslope Park, Olney, Sherington, Newport Pagnell North, Newport Pagnell South, Linford North	666
Walton Park, Danesborough, Middleton, Woughton	846
Stantonbury, Stony Stratford and Wolverton	775
Outer catchment area: - (Buckingham, Winslow, Leighton Buzzard, Linslade, Woburn Sands, Hanslope, Old Stratford, Beachampton, The Horwoods, The Brickhills, Woburn)	408
Extended catchment area, that includes the remainder of the county area of Northamptonshire, Buckinghamshire and Bedfordshire (not already covered in the outer catchment area) the unitary council area of Luton and the district council areas of Cherwell, Oxford City and South Oxfordshire.	123
Total	**5,550**

The Trust currently has 5,550 public members and 2,927 staff members on its membership register. The total membership is therefore 8477.

2.3.3 Membership Recruitment and Engagement

The Trust's membership continues to be developed by the governor and membership manager. The Engagement Group and some of the Trust's governors have been very active in assisting to recruit new members.

The Engagement Group has refreshed and revised the membership and engagement strategy that was adopted by the Council of Governors in March 2018.

The strategy has the following three objectives:

Objective 1
Build and maintain membership numbers to meet / exceed annual plan targets ensuring the membership is representative of the population the Trust serves.

Objective 2
Regular and effective communication with members.

Objective 3
Engage with members and encourage their involvement.

An action plan to deliver these objectives has been developed, and is being actively monitored by the Engagement Group. Actions include increasing membership by developing an engagement plan, and providing information and presentations to local voluntary organisations and community groups about the benefits and importance of membership.

The Council of Governors' Youth Cabinet appointed representatives who provide views on the services provided for young people, invited the trust to take part in the Big Youth MK Debate along with other health related organisations where young people from schools across Milton Keynes were able to ask questions and give views on local health services. .

Trust staff and governors continue to talk with partner and external organisations. The governor and membership manager and governors were also involved in the Healthwatch event in September 2017 when new members were signed up. In August 2017, Governors were able to engage and sign up new members with those in attendance at The MK Play day event held that provided free, fun accessible activities for all children, young people and their families from across Milton Keynes where around 9000 people were in attendance at the event.

The engagement group have also developed a leaflet for the residents in their constituency and the local community council providing information on the role of Governors and how they can be contacted.

The Trust is committed to engaging with individuals or groups who find joining the membership difficult, unappealing, or who are unaware of hospital membership.

2.3.4 Contacting the Council of Governors

Anyone wishing to contact our Council of Governors or enquire about becoming a member can do so in writing or by using a dedicated membership email address.

Foundation.Members@mkuh.nhs.uk. Contact can also be made directly by telephoning the governor and membership manager on 01908 996235.

2.4.1 Patient Care

The Trust has continued to improve care quality and patient services, with examples in the performance and quality reports. The Trust monitors quality and key targets closely, with detailed narrative and data available in the performance report and dashboard.

2.5.1 Care Quality Commission Inspections and Action Plans

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

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

Overall Ratings for Milton Keynes University Hospital:

Specialty Area	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	★ Outstanding	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and Gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of Life Care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and Diagnostic Imaging	Good	Not Rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Key findings from the report:

- All staff were compassionate about providing high quality care
- The emergency department was meeting the four hour target with clear escalation processes to allow for proactive plans to be put into place for patient flow.
- The HSMR 9 Hospital standardised mortality (ratio) was significantly better than the expected rate.
- Improvements had been made in the completion and review of patients "do not attempt cardio pulmonary resuscitation" forms.
- There was a lower rate than the average of neonatal deaths. The Maternity Improvement Board was monitoring this to make further improvements to the service.
- Staffing levels were appropriate and met patients' needs at the time of the inspection.
- Staff morale was positive and staff spoke highly of the support from their manager.
- Local ward leadership was effective and ward leaders were visible and respected.

Areas of outstanding practice:

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

Areas of compliance or enforcements actions:

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:

- The emergency department did not comply with guidance relating to both paediatric and adult mental health facilities.
  The Trust has built a dedicated mental health assessment room and improved its security to the paediatric emergency department.

- Staff, patients and visitors did not appear to observe the handwashing protocols in the emergency department.
  The Trust has introduced more regular audit of the handwashing protocols in the department.

- The non-invasive ventilation policy was out of date.
  This has been re written and approved

- The Medical Care Service did not have a policy for dealing with outlying patients.
  This has been updated due to recent ward reconfigurations.

- In the maternity service examples were shared of inappropriate behaviours and lack of teamwork at consultant level in the service. These behaviours were not observed during the inspection.
  The Trust has invested in multi-disciplinary leadership and human factors training which includes all of the consultant body. In addition timetables have been rescheduled to allow for team meetings and more multi-disciplinary ward rounds.

- Not all medical staff in maternity had completed the required level of safeguarding children training.
  Compliance is presently over 90%.

- There was poor compliance with assessing the risk of venous thromboembolism in the maternity service.
  A new process is now in place.

2.5.2 Improvements in Patient/ Carer Information

The Trust has adopted the Patient Accessible Information Standard and continually seeks opportunities to improve patient and carer information to improve access to care and services and support decision-making.

2.5.3 Information on Complaints Handling

The Trust has a complaints and patient advice and liaison service to co-ordinate the investigation, response and resolution of complaints within statutory timeframes. The Trust is continually seeking to improve the way in which complaints and issues are managed, particularly in involving and empowering patients and families more effectively through the complaints process.

2.5.4 Stakeholder Relations

The Trust's policy is to engage, involve and consult with the public, patients, carers and other stakeholders on improving the care we provide. We do this by finding out what our patients and other stakeholders think about the care they have received and, through our Council of Governors, asking for views on our longer-term plans. Members are not just informed of issues regarding the Trust, but are actively involved in shaping services.

While the main forum for representing the interests of patients, carers, employees and the local community is through the Council of Governors, we have started a number of initiatives to open up channels for the wider community. For example we held our first Big Conversation which provided both staff and local residents the opportunity to hear first-hand what is happening at the hospital as well as an opportunity to ask executives questions on current issues and developments.

Milton Keynes Clinical Commissioning Group

The Trust has established a working relationship with the CCG for the contract negotiations and longer term health care planning.

Health and Adult Social Care Select Committee

The chief executive, the chairman and governors have continued to keep the elected representatives of Milton Keynes Council and in particular, the Health and Adult Social Care Committee appraised of service issues at the Trust. The Council have continued to support the strategic direction of the Trust. In addition, the Council has a representative on the Council of Governors, Councillor Andrew Buckley.

Health and Wellbeing Board

The Chief Executive represents the Trust on the Health and Wellbeing Board and reports any issues back to the Trust Board and governors, as appropriate.

Milton Keynes Adult Safeguarding Board

The Trust is an active member of the Milton Keynes Safeguarding Adults Board, the local group responsible for overseeing Safeguarding. It is a multi-agency group with representatives from the council, health services, police, voluntary sector and independent inspection and regulation services.

Healthwatch Milton Keynes

Throughout 2017/18 collaboration continued as appropriate between the Council of Governors and Healthwatch Milton Keynes. The remit of both the Council of Governors and Healthwatch is complementary; both bodies representing the health interests and concerns of the members and people of Milton Keynes. The chair of Healthwatch Milton Keynes is an appointed governor on the Council of Governors and another governor is a co-opted member of the Healthwatch Milton Keynes Management Board. Participation has been undertaken in various events including involvement from Healthwatch at the Governors' Annual Members' Meeting and Governors involvement in the Health event held at the centre:mk with stalls on diagnostic services, patient experience and membership.

2.5.5 Other Patient and Public Involvement Activity

The Trust has a diverse range of patient and public involvement activity and has significantly developed opportunities for involvement throughout the year. Examples include the 15 Steps initiative; the Big Conversation; engagement workshops and public meetings on the STP; PLACE assessments; and patient and carer stories at the Board and Council of Governors.

2.6.1 Statement as to Disclosure to the Auditors

The Executive and Non-Executive Directors who held office at the date of the approval of the Directors' report confirm that, so far as they are aware, there is no relevant audit information of which the auditor is not aware. They also confirm that they each have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that Deloitte LLP is made aware of such information.

2.7 REMUNERATION REPORT

The Remuneration Report describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration, as required by the Companies Act 2006, Regulation 11 and Schedule 8 of the Large and Medium-Sized Companies and Groups (Accounts and Reports) Regulations 2008, and the NHS Foundation Trust Code of Governance.

The Remuneration Report comprises three parts:

1. Annual statement on remuneration
2. Senior managers' remuneration policy
3. Annual report on remuneration

2.7.1 Annual Statement on Remuneration

For the period until 31 March 2018 there were no Trust Board members employed via non-payroll means.

A number of Board level changes took place in 2017/18. Mike Keech, interim director of finance, was appointed substantively to the role on 26th March 2018. Emma Goddard continued her secondment to the BLMK STP as programme director but now on a full time basis. The medical director's role was expanded to include research and development.

There were eight non-executive and nine executive directors on the Board of Directors in 2017/18. Simon Lloyd, who as deputy chairman took up the role of acting chairman following the death of Baroness Margaret Wall, was appointed as the substantive chairman in November 2017 following a competitive selection process. David Moore left the Board in February 2018 having completed two full terms totaling six years. In March 2018, Heidi Travis and Helen Smart were appointed to the Board, again following a competitive selection process, and John Clapham was nominated by the University of Buckingham to be their representative on the Board in accordance with the Trust's constitution.

There have been no payments to past senior managers.

As a result of the additional responsibilities attached to the Medical Director's portfolio, the Remuneration Committee approved an increase to his salary in line with national benchmarking. The Remuneration Committee also approved an increase to the salaries of the Director of Patient Care and Chief Nurse and the Director of Corporate Affairs. This was in order to ensure that there were no gender pay anomalies, as highlighted in a letter of 8 November 2017 from Jim Mackey, Chief Executive of NHS Improvement, regarding 2017/18 consolidated pay increase for Very Senior Managers (VSMs). All payments were made in line with NHS Improvement's Guidance on VSM in NHS trusts and foundation trusts - February 2017.

The Remuneration Committee took the decision to award a 1% increase to executive pay for the period 2017/18, in line with Jim Mackey's letter. All other staff employed by the Trust are covered by national pay awards under the Agenda for Change framework or the Medical and Dental terms and conditions of service.

The remuneration for non-executive directors is set by the Council of Governors and is subject to benchmarking with comparable remuneration for this role at other Trusts.

In response to the Treasury recommendation, the Trust has incorporated into its standard contractual terms and conditions the requirement to allow the Trust to seek assurance around tax obligations.

In line with the Secretary of State for Health's request in his letter of 2nd June 2015, I personally scrutinise and approve the remuneration of very senior managers to ensure that they are necessary and justifiable.

2.7.2 Senior Managers' Remuneration Policy

FUTURE POLICY TABLE					
Item	**Salary/Fees**	**Taxable Benefits**	**Annual Performance Related Bonus**	**Long Term Related Bonus**	**Pension Related Benefits**
Support for the short and long term objectives of the Foundation Trust	Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives	None disclosed	None paid	None paid	Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives
How the component operates	Paid in even twelfths	None disclosed	None paid	None paid	Employee and employer contributions
Maximum payment	As set out in the Accounts	None disclosed	None paid	None paid	Not applicable
Framework used to assess performance	Trust appraisal system	None disclosed	None paid	None paid	Not applicable
Performance measures	Tailored to individual posts	None disclosed	None paid	None paid	Not applicable
Amount paid for minimum level of performance and any further level of performance	Salaries are agreed on appointment and set out in the contract of employment	None disclosed	None paid	None paid	Not applicable
Explanation of whether there are any provisions for recovery of sums paid to directors or provisions for withholding payments	Any overpayments may be recovered	None disclosed	None paid	None paid	Not applicable

Non-executive Directors are appointed on fixed terms contracts, normally three or four years in length, and they do not gain access to the Pension Scheme as a result of this engagement. The fee payable to Non-executive Directors is set out in the table on page 64. They do not receive any other payments from the Trust.

2.7.2.1 Service Contract Obligations and Policy on Payment for Loss Office

All executive directors are employed on permanent or fixed term contracts and are required to give six months' notice to terminate their contract. In line with NHS Employers' guidance, the notice period for the Trust's very senior managers (VSMs) is six months. Terms of each of the non-executive directors are given in the details of the Board members from page 38.

Payment for loss of office is covered within contractual notice periods and standard employment policies and legislation.The Trust has made no provision for compensation for early termination and no payment for loss of office for senior managers.

2.7.2.1 Trust's Consideration of Employment Conditions

Other members of staff who are not Board members are employed on agenda for change terms and conditions and any percentage pay increases are applied in accordance with national agreements. The Remuneration Committee agrees senior managers' pay and conditions following consideration of benchmarking information on comparable roles. It is through this benchmarking that the pay for senior managers above the level of £150,000 was maintained for 2017/18. Employees of the Trust are not consulted on senior manager remuneration.

2.7.3 Annual Report on Remuneration

The Remuneration Committee is a sub-committee of the Trust Board. It is chaired by the Trust Chairman and comprises all the non-executive directors (names of non-executive directors are listed in the table below). The Committee meets as required, but its terms of reference recommend that this should be at least twice a year. Its main role is to agree the salaries and remuneration packages of the chief executive and the executive directors. The Chief Executive and the Director of Workforce attend the meeting, but leave when discussions about their own positions are to be discussed.

The Remuneration Committee met three times in 2017/18. Information on attendance is contained within the Directors' Report.

The Trust reviewed its remuneration practice relating to executive directors during 2017/18 and has agreed a remuneration policy and strategy. The policy reflects recent practice of not linking director pay progression to individual performance and of not having performance related bonuses. Both local and national benchmarking information regarding remuneration will continue to be provided to the remuneration committee. Further, in line with the Secretary and State for Health's letter of 2nd June 2015 to chairs of NHS Trusts, the Trust reviews the amounts paid to directors to ensure that they are necessary and justifiable. The Chairman personally scrutinises and approves any new very senior manager appointment in the Trust.

2.7.4 Tenure and notice periods of Board of Directors

NON EXECUTIVE DIRECTORS				
Name	**Appointment**	**Date of Appointment**	**Unexpired Term**	**Notice period**
Robert Green	Non-executive director	Jan 2013	Jan 2019	1 month
Simon Lloyd	Chairman	May 2015	April 2021	1 month
Tony Nolan	Non-executive director	March 2014	Feb 2020	1 month
Andrew Blakeman	Non-executive director	Feb 2016	Feb 2019	1 month
Parmjit Dhanda	Non-executive director	March 2017	March 2020	1 month
Helen Smart	Non-executive director	March 2018	February 2022	1 month
Heidi Travis	Non-executive director	March 2018	February 2021	1 month
John Clapham	Non-executive director	March 2018	February 2020	1 month

EXECUTIVE DIRECTORS				
Name	**Appointment**	**Date of Appointment**	**Unexpired Term**	**Notice period**
Joe Harrison	Chief Executive	Feb 2013	N/A	6 months
Lisa Knight	Director of Patient Care and Chief Nurse	Oct 2012	N/A	6 months
Ian Reckless	Medical Director	April 2016	N/A	6 months
John Blakesley	Deputy Chief Executive	Apr 2014	N/A	6 months
Ogechi Emeadi	Director of Workforce	Mar 2014	N/A	6 months
Mike Keech	Director of Finance	Dec 2016	N/A	6 months
Kate Jarman	Director of Corporate Affairs	May 2014	N/A	6 months
Caroline Hutton	Director of Clinical Services	Oct 2014	N/A	6 months
Emma Goddard	Director of Service Development	Dec 2014	N/A	6 months

OTHER BOARD MEMBERS DURING 2017/18				
Name	**Appointment**	**Date of Appointment**	**Unexpired Term**	**Notice period**
David Moore	Non-executive director	March 2012	Tenure ended in February 2018	1 month

Details of remuneration, including salaries and pension entitlements of the board of directors are published in section 4.6 in the annual accounts. Details on the median/mid-point and highest paid director are included in this section of the annual accounts. The banded remuneration of the highest paid director in the Trust in the financial year 2017/18 was £175,000-£180,000 (2016/17 £175,000-180,000). This was 5.89 times (2016/17 5.91 times) the median remuneration of the workforce, which was £30,424, (2016/17 £30,333).

The details of other remuneration, travel and assistance for directors and non-executive directors are attached in table 1.

The only non-cash element of the senior managers' remuneration packages are pension related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme, which apply to all NHS staff.

With the exception of benefits payable under the NHS pension scheme in respect of early retirement (whether this might be actuarially reduced or ill-health related), no further benefit is payable to a senior manager in the event of their early retirement. Furthermore, no service contract obligations apply which could give rise to, or impact on, remuneration payments or payments for loss of office.

The Trust's normal disciplinary policies apply to senior managers, including the sanction of summary dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff

The Trust has a policy in place that reviews the employment status of contractors to assess if the contractor is an employee or self-employed as per HMRC's assessment criteria; this has been updated in year to take account of HMRC's amendment to the 'IR35' (personal service company) regulations. The Trust's policy is not to employ anyone through their own company if they do not meet the self-employment status.

2.7.5 Governor Expenses

Governors are permitted to claim an allowance of £10 for any meeting of the Council of Governors they attend or an external meeting that they attend on behalf of the Trust e.g. Healthwatch Milton Keynes Executive. Details of the claims made in 2017/18 are attached at table 2. Details of Governors who held office in 2016/17 are given at Appendix 1.

	Year Ended 31 March 2018					
	Salary	Taxable Benefits	Annual Performance Related bonuses	Long term Performance Related bonuses	Pension Benefits	Total
Name and title	(Bands of £5,000) £	(Bands of £100) £	(Bands of £5,000) £	(Bands of £5,000) £	(Bands of £2,500) £	(Bands of £5,000) £
Joe Harrison Chief Executive Officer	175-180	0	0	0	50-52.5	**225-230**
Mike Keech Director of Finance	115-120	0	0	0	25-27.5	**145-150**
Lisa Knight Director of Patient Care / Chief Nurse	110-115	0	0	0	32.5-35	**140-145**
John Blakesley Deputy Chief Executive	150-155	0	0	0	N/A	**150-155**
Ogechi Emeadi Director of Workforce	100-105	0	0	0	30-32.5	**130-135**
Ian Reckless Medical Director	165-170	0	0	0	117.5-120	**285-290**
Emma Goddard Director of Service Development	110-115	0	0	0	27.5-30	**140-145**
Kate Jarman Director of Corporate Affairs	85-90	0	0	0	52.5-55	**140-145**
Caroline Hutton Director of Clinical Services	130-135	0	0	0	150-152.5	**280-285**
Simon Lloyd Chairman	45-50	0	0	0	N/A	**45-50**
Tony Nolan Non Executive Director	10-15	0	0	0	N/A	**10-15**
Robert Green Non Executive Director	10-15	0	0	0	N/A	**10-15**
David Moore (to 18th February 2018) Senior Independent Director	10-15	0	0	0	N/A	**10-15**
Andrew Blakeman Non Executive Director	10-15	0	0	0	N/A	**10-15**
Parmjit Dhanda Non Executive Director	10-15	0	0	0	N/A	**10-15**
Helen Smart (from 1st March 2018) Non-Executive Director	0-5	0	0	0	N/A	**0-5**
Heidi Travis (from 1st March 2018) Non-Executive Director	0-5	0	0	0	N/A	**0-5**
John Clapham (from 1st March 2018) Non-Executive Director	0-5	0	0	0	N/A	**0-5**

Name and title	Year Ended 31 March 2017 Salary (Bands of £5,000) £	Taxable Benefits (Bands of £100) £	Annual Performance Related bonuses (Bands of £5,000) £	Long term Performance Related bonuses (Bands of £5,000) £	Pension Benefits (Bands of £2,500) £	Total (Bands of £5,000) £
Joe Harrison Chief Executive Officer	170-175	0	0	0	32.5-35	**220-225**
Jonathan Dunk Director of Finance (left 10/4/16)	0-5	0	0	0	45-47.5	**0-5**
Sophia Aldridge Acting Director of Finance (11/4-14/12/16)	85-90	0	0	0	22.5-25	**85-90**
Mike Keech Interim Director of Finance (from 1/12/16)	35-40	0	0	0	0	**60-65**
Lisa Knight Director of Patient Care / Chief Nurse	105-110	0	0	0	40-42.5	**135-140**
John Blakesley Deputy Chief Executive	150-155	0	0	0	72.5-75	**160-165**
Ogechi Emeadi Director of Workforce	100-105	0	0	0	37.5-40	**120-125**
Ian Reckless Medical Director (from 18/4/16)	140-145	0	0	0	72.5-75	**260-265**
Emma Goddard Director of Service Development	110-115	0	0	0	7.5-10	**135-140**
Kate Burke Director of Corporate Affairs	80-85	0	0	0	15-17.5	**135-140**
Caroline Hutton Director of Clinical Services	110-115	0	0	0	N/A	**145-150**
Baroness Margaret Wall Chairman (deceased 25/1/17)	35-40	0	0	0	N/A	**35-40**
Simon Lloyd Acting Chairman (26/1/17-to present)	5-10	0	0	0	N/A	**5-10**
Tony Nolan Non Executive Director	10-15	0	0	0	N/A	**10-15**
Dr Jean-Jacques De Gorter Non Executive Director	10-15	0	0	0	N/A	**10-15**
Robert Green Non Executive Director	10-15	0	0	0	N/A	**10-15**
David Moore Senior Independent Director	10-15	0	0	0	N/A	**10-15**
Andrew Blakeman Non Executive Director	10-15	0	0	0	N/A	**10-15**
Parmjit Dhanda Non Executive Director (from 1/3/17)	0-5	0	0	0	N/A	**0-5**


Fire exit

Salaries and Expenses - Directors' Remuneration Statement 2017/18

Name and title	Non Taxable Expenses: Other Remuneration (To the nearest £100) £	Non Taxable Expenses: Travel & Subsistence (To the nearest £100) £
Joe Harrison Chief Executive Officer	1,400	2,700
Mike Keech Director of Finance	0	0
Lisa Knight Director of Patient Care / Chief Nurse	0	1,700
John Blakesley Deputy Chief Executive	0	0
Ogechi Emeadi Director of Workforce	0	200
Ian Reckless Medical Director	800	2,600
Emma Goddard Director of Service Development	0	800
Kate Jarman Director of Corporate Affairs	100	100
Caroline Hutton Director of Clinical Services	0	500
Simon Lloyd Chairman	0	500
Tony Nolan Non Executive Director	0	700
Robert Green Non Executive Director	0	0
David Moore (to 18th February 2018) Senior Independent Director	900	800
Andrew Blakeman Non Executive Director	0	0
Parmjit Dhanda Non Executive Director	0	400
Helen Smart (from 1st March 2018) Non-Executive Director	0	0
Heidi Travis (from 1st March 2018) Non-Executive Director	0	0
John Clapham (from 1st March 2018) Non-Executive Director	0	0

Salaries & Expenses - Directors Remuneration Statement 2016/17

Name and title	Non Taxable Expenses: Other Remuneration (To the nearest £100) £	Non Taxable Expenses: Travel & Subsistence (To the nearest £100) £
Joseph Harrison Chief Executive Officer	600	4,700
Jonathan Dunk Director of Finance (left 10/4/16)	0	0
Sophia Aldridge Acting Director of Finance (11/4-14/12/16)	0	500
Mike Keech Interim Director of Finance (from 1/12/16)	0	0
Lisa Knight Director of Patient Care / Chief Nurse	0	200
John Blakesley Deputy Chief Executive	0	100
Ogechi Emeadi Director of Workforce	0	0
Ian Reckless Medical Director (from 18/4/16)	0	1,800
Emma Goddard Director of Service Development	0	600
Kate Burke Director of Corporate Affairs	0	200
Caroline Hutton Director of Clinical Services	8,000	100
Baroness Margaret Wall Chairman (deceased 25/1/17)	0	0
Simon Lloyd Acting Chairman (26/1/17-to present)	0	0
Tony Nolan Non Executive Director	0	700
Dr Jean-Jacques De Gorter Non Executive Director	0	0
Robert Green Non Executive Director	0	0
David Moore Senior Independent Director	300	900
Andrew Blakeman Non Executive Director	0	0
Parmjit Dhanda Non Executive Director (from 1/3/17)	0	0

Salaries and Allowances

Name and Title	Real increase in pension at pension age (Bands of £2.5k) £000	Real increase in pension lump sum at pension age (Bands of £2.5k) £000	Total accrued pension at pension age at 31st March 2018 (Bands of £5k) £000	Lump sump at pension age related to accrued pension at 31st March 2018 (Bands of £5k) £000	Cash Equivalent Transfer Value at 31st March 2017 (Bands of £1k) £000	Real Increase in Cash Equivalent Transfer Value (Bands of £1k) £000	Cash Equivalent Transfer Value at 31st March 2018 (Bands of £1k) £000	Employer's contribution to stakeholder pension (Bands of £1k) £000
Joe Harrison Chief Executive Officer	2.5-5	0-2.5	55-60	140-145	970	0	920	20
Mike Keech Director of Finance	0-2.5	0	0-5	0	9	14	23	17
Lisa Knight Director of Patient Care / Chief Nurse	0-2.5	0-2.5	40-45	110-115	675	71	746	16
John Blakesley ** Deputy Chief Executive	N/A	N/A	N/A	N/A	964	N/A	N/A	N/A
Ogechi Emeadi Director of Workforce	0-2.5	0-2.5	30-35	85-90	508	57	565	15
Caroline Hutton Director of Clinical Services	7.5-10	15-17.5	40-45	100-105	549	157	706	19
Kate Jarman Director of Corporate Affairs	2.5-5	2.5-5	10-15	20-25	109	37	146	13
Emma Goddard * Director of Service Development	0-2.5	0	15-20	N/A	100	23	123	16
Ian Reckless Medical Director	0-2.5	10-12.5	30-35	90-95	421	37	458	12

NOTES

* Emma Goddard is in the 2008 pension scheme for which there is no information available relating to lump sum.

** John Blakesley opted out of the pension scheme Dec 16 and has made no contribution to the scheme during 2017/18. Therefore no information is available

Name and Title	Real increase in pension at aged 60 (Bands of £2.5k) £000	Lump sum at aged 60 related to real increase in pension (Bands of £2.5k) £000	Total accrued pension aged 60 at 31st March 2017 (Bands of £5k) £000	Lump sum at aged 60 accrued pension at 31st March 2017 (Bands of £5k) £000	Cash equivalent transfer value at 31st March 2016 (Bands of £1k) £000	Real increase in Cash equivalent transfer value (Bands of £1k) £000	Cash equivalent transfer value at 31st March 2017 (Bands of £1k) £000
Joe Harrison Chief Executive Officer	2.5-5	0-2.5	50-55	135-140	757	203	960
Jonathan Dunk Director of Finance (to 10.4.16)	0	0	0	50-55	275	0	263
Mike Keech Interim Director of Finance (from 1.12.16)	0-2.5	0	0-5	0	0	3	9
Lisa Knight Director of Patient Care / Chief Nurse	0-2.5	0-2.5	40-45	110-115	629	39	669
John Blakesley Deputy Chief Executive	0-2.5	0	30-35	100-105	920	34	954
Ogechi Emeadi Director of HR & Workforce Development	0-2.5	0	30-35	80-85	470	32	503
Caroline Hutton Director of Operations	0-2.5	0	30-35	85-90	506	37	543
Sophia Aldridge Interim Director of Finance (from 10.4.16 to 1.12.16)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kate Burke Director of Corporate Services	0-2.5	0	10-15	20-25	84	15	107
Emma Goddard * Director of Service Improvement	0-2.5	0	10-15	N/A	82	17	99
Ian Reckless Medical Director (from 18.4.16)	6-6.5	5-7.5	30-35	75-80	339	48	417

NOTES

Sophia Aldridge opted out of the pension scheme on 1st December 2016 and there is therefore, no information relating to the pension scheme.

*Emma Goddard is in the 2008 pension scheme for which there is no information available relating to lump sum

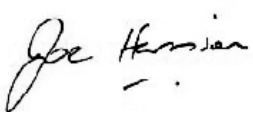

3
Noah

Governor Expenses 2017/18

Governor	Amount £
Douglas Campbell	70.00
Alan Hastings (Lead Governors' Network Meeting Apr 2017 & Deloitte Seminar)	49.87
Total	**119.87**

Governor Expenses 2016/17

Governor	Amount £
Siddhartha Nandi-Purkayastha (March 2017)	20.00
Alan Hastings (Lead Governors' Network Meeting February 2017)	74.70
Carolyn Peirson (Aug to Dec 2016)	60.00
Carolyn Peirson (to March 2016, but paid in July 2016)	140.00
Douglas Campbell (Apr to Jun 2016)	320.00
Alan Hastings (to May 2016)	40.00
Total	**654.70**



Joe Harrison
CHIEF EXECUTIVE

Date: 25 May 2018

2.8 STAFF REPORT

This section of the report provides information on staff, including staff numbers, costs and key workforce performance information.

2.8.1 Analysis of Staff Costs

(subject to audit)

Staff Costs	Permanently Employed £000	Other £000	Total £000
Employee expenses - staff	145,445	12,561	158,006
Employee expenses – executive directors	1,317	0	1,317
Total	**146,762**	**12,561**	**159,323**

Staff Costs	Permanent £000	Other £000	2017/18 Total £000	2016/17 Total £000
Salaries and wages	119,353	1,109	**120,462**	112,676
Social security costs	13,121	0	**13,121**	11,314
Apprenticeship levy	616	0	**616**	0
Employer's contribution to NHS pensions	13,672	0	**13,672**	12,604
Temporary staff	0	11,452	**11,452**	17,647
Total	**146,762**	**12,561**	**159,323**	**154,241**

2.8.2 Analysis of Average Staff Numbers

The table below shows a breakdown of our average workforce by staff group as at 31 March 2018.

Staff Group	Bank	Fixed Term Temp	Locum	Non-Exec Director/ Chair	Permanent	Headcount
Add Prof Scientific and Technic	29	2	-	-	91	123
Additional Clinical Services	627	9	-	-	581	1,217
Administrative and Clerical	113	57	-	6	687	863
Allied Health Professionals	32	4	0	-	166	203
Estates and Ancillary	39	12	-	-	327	378
Healthcare Scientists	18	1	-	-	80	98
Medical and Dental	50	165	107	-	254	576
Nursing and Midwifery Registered	267	24	-	-	978	1,269
Total	**1,175**	**274**	**107**	**6**	**3,165**	**4,727**

Average number of employees (WTE basis)	Permanent number	Other number	2017/18 Total number	2016/17 Total number
Medical and Dental	405	40	**445**	424
Administration and estates	398	43	**441**	439
Healthcare assistants and other support staff	960	189	**1,149**	1,099
Nursing, midwifery and health visiting staff	822	203	**1,025**	1,003
Scientific, therapeutic and technical staff	278	19	**297**	289
Healthcare science staff	25	6	**31**	30
Other	7	1	**8**	6
Total	**2,895**	**501**	**3,396**	**3,290**

Average WTE - 2017/18 (subject to audit)

Staff Group	Assignment Category			
	Fixed Term Temp	Non-Exec Director/Chair	Permanent	Total
Add Prof Scientific and Technic	2.54		79.16	**81.69**
Additional Clinical Services	8.62		489.77	**498.39**
Administrative and Clerical	53.27	5.77	599.97	**659.01**
Allied Health Professionals	4.43		141.50	**145.93**
Estates and Ancillary	7.14		239.86	**246.99**
Healthcare Scientists	0.54		72.23	**72.77**
Medical and Dental	161.97		243.46	**405.42**
Nursing and Midwifery Registered	19.57		841.76	**861.33**
Total	**258.07**	**5.77**	**2,707.70**	**2,971.53**

The following is a breakdown of staff by gender:

Headcount of Staff with Substantive Contracts

Staff Group	Female	Male	Total
Directors	7	10	17
Other Senior Managers	0	0	0
Employees	2,803	685	3,488
Total	**2,810**	**695**	**3,505**

As at 31 March 2018, the Trust Board comprised; eight non-executive directors (six male) and eight executive directors (four male and four female).

2.9.3 Absence rate for year 01/02/2017 to 31/03/2018:

Sickness absence - 2017/18

Trust Absence 12 months to 31 March 2018	Cumulative Abs (WTE) Days	Cumulative Avail (WTE) Days	Cumulative % Abs Rate (WTE)	Short Term % Abs Rate (WTE)	Long Term % Abs Rate (WTE)	No of Episodes
All Staff Groups	44,654	1,081,392	4.13%	1.80%	2.33%	7,052

Sickness absence - 2016/17

Trust Absence 12 months to 28 February 2017	Cumulative Abs (WTE) Days	Cumulative Avail (WTE) Days	Cumulative % Abs Rate (WTE)	Short Term % Abs Rate (WTE)	Long Term % Abs Rate (WTE)	No of Episodes
All Staff Groups	45,093	1,043,400	4.32%	1.85%	2.47%	7,067

The top ten reasons for absence for the Trust are now reportable as a result of improvements that have been made to our absence returns. Work has commenced, in year, to improve the level of 'unknown' absence through a revised return to work process and stronger procedural guidance in a revised sickness absence and attendance policy.

The health and wellbeing of our staff continues to be a priority for the Trust, in terms of improving workforce effectiveness and its effect on patient care. By focusing on 'hotspot' areas of sickness absence, we have been able to bring conclusions to long term individual cases and identify areas of best practice to champion and from which to learn.

2.8.4 Expenditure on consultancy

The Trust's expenditure on consultancy in 2017/18 was £350,000.

2.8.5 Staff Policies and actions applied during the Financial Year

Our recruitment and selection policy ensures that we are able to give full and fair consideration to applications for employment made by disabled persons. All of our jobs are advertised on the national NHS jobs website and our newly implemented electronic recruitment system TRAC, which not only promotes equal opportunities at the recruitment stage, but also allows disabled candidates to declare known or suspected conditions and how we might overcome these by adjusting our selection activities. Such conditions are made known to recruiting managers by the recruitment team after the shortlisting process has taken place to ensure that no discrimination can occur, whether direct or indirect.

The Trust has various means of supporting employees to continue their employment and receive training and retraining in the event that they should become disabled persons during their Trust employment. A comprehensive sickness absence management policy and working with disabilities guidance provide policy and procedural guidance in this regard and manager, colleagues and interventions such as adjustments to working roles and redeployments are supported and facilitated by specialist occupational health, HR advisor and HR business partner input. External agencies, such as Access to Work and Remploy are also engaged on a case-by-case basis, where it is believed that the Trust, its managers or its colleagues could benefit from more expert, technical or financial support.

The Trust's appraisal and statutory and mandatory training policies provide that training, career development and promotion of disabled employees are facilitated through individualised actions and personal development plans that are aligned to the Trust's core values. Such an approach promotes equal opportunities through promotion of learning and development and it also seeks to reduce the impact of potential inequalities caused by the condition of disability of an individual in a supportive way.

In terms of engagement, the Trust uses various means of communicating matters of concern to our workforce. Such an approach ensures no group is left without receiving key messages. The discussions and outcomes of Trust meetings, such as management board, are cascaded through to colleagues in person and via email, monthly newsletters are produced and the intranet is increasingly being used for this purpose, in addition to the staff forum/bulletin board. Furthermore, the workforce and organisational development teams have developed their own website over the course of the 2017/18, providing another accessible platform for information sharing, networking and engagement. During 2017/18, the Trust changed its payroll providers from NHS Shared Business Services to University Hospitals Birmingham (UHB). UHB produce payroll and pensions leaflets and undertake payslip messaging as part of their contract with the Trust. 'All acute users' emails are routinely used in addition to a variety of on-site and web based seminars, such as the Chief Executive's Roadshows and the Chief Executive's leadership forums. More recently, the Trust has made more use of local surveys via its web based applications, e.g. health and wellbeing survey, temporary staffing survey, staff friends and family test. These are also used to encourage staff to become involved in the Trust's performance. Such engagement activities have become increasingly important in 2017/18 as the Trust has sought to celebrate its successes and to continue its drive for excellence and an 'Outstanding' CQC rating.

The Trust has a longstanding recognition agreement with staff side partners, the terms of which were reviewed in 2017/18 and updated to include greater participation from the medical and dental joint local negotiating committee (JLNC), chaired by the medical director. The recognition agreement also provides the framework for regular joint consultative and negotiation committee (JCNC) meetings which are chaired on an alternate basis by the staff side chair and the director of workforce.

A full and comprehensive review of all workforce policies and procedures commenced in 2016/17 under the guidance of the JCNC to ensure that we seek to align to regional policy/direction or differentiate in order to set us apart, depending on specific need/aim or purpose (e.g. becoming an employer of choice in the region). In 2017/18 the Trust reviewed and/or approved 10 of its 39 workforce, education and learning policies. Six further new workforce policies are under development highlighting the rigour with which the Trust is seeking to support and develop its workforce.

Furthermore, the Trust's management of organisational change policy provides framework agreed in partnership with staff side colleagues for consultations. In this way, early staff side involvement in organisational change programmes is gained to capitalise on consultation opportunities in a meaningful way with our colleagues and their representatives. Staff side colleagues are also involved and engaged in key Trust activities such as the equality and diversity network, the on-call working group, workforce transformation programme board, and job matching panels, and We Care steering group.

Together these ensure that the views of staff are sought in a holistic and inclusive way, demonstrating the Trust's ongoing commitment to partnership working.

The Trust has numerous policies and procedures with regard to countering fraud. The Trust has a comprehensive set of standing financial instructions (SFIs) and a standalone counter fraud and reporting policy, including the involvement and roles of internal and external auditors. Separate to these, the Trust has its own gifts, donations and hospitality declarations policy in addition to specific clauses in the standard Trust contract of employment covering this area.

In line with critical national requirements, in 2017/18 the Trust also continued to support key employee relations activity by promoting its Freedom to Speak Up Guardians (whistleblowing), Guardian of Safer Working (medical and dental) and the constitution and participation of its Junior Doctors' forum.

2.8.6 Staff side time spent on union facilities

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force in April 2017. The regulations require that NHS employers publish certain information about trade union officials and facilities time. The following tables show facilities activity and cost among the unions that are recognised by the Trust over the course of 2017/18. These figures are collated and reported on a monthly basis to the Trust's joint consultative and negotiation committee (JCNC).

Table 1 - Relevant union officials

Table 1 outlines the total number of MKUH employees who were relevant union officials during 2017/18.

NUMBER OF EMPLOYEES WHO WERE RELEVANT UNION OFFICIALS DURING THE RELEVANT PERIOD	FULL-TIME EQUIVALENT EMPLOYEE NUMBER
26	23.56

Table 2 - Percentage of time spent on facility time

Table 2 outlines the number of MKUH employees who were relevant union officials employed during the 2017/18 who spent (a) 0%, (b) 1%-50%, (c) 51%-99% or (d) 100% of their working hours on facility time.

PERCENTAGE OF TIME	NUMBER OF EMPLOYEES
0%	5
1-50%	21
51%-99%	
100%	

Table 3 - Percentage of pay bill spent on facility time

Table 3 provides the percentage of the MKUH total pay bill spent on paying employees who were relevant union officials for facility time during 2017/18.

DESCRIPTION	FIGURES
Total cost of facility time	£27,987.19
Total pay bill	£1,787,561.75
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	1.56%

Table 4 - Paid trade union activities

Table 4 provides the number hours spent by employees who were relevant union officials during 2017/18 on paid trade union activities, expressed as a percentage of total paid facility time hours,

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	3.07%

2.8.7 Health and Safety Performance and Staff Health and Wellbeing

In line with the strategic workforce direction for 2017/18, a greater focus was placed on Occupational Health. The service was rebranded as the 'Staff Health and Wellbeing' department (SH&WB) in support of the strategic aims of the Trust's Health and Wellbeing strategy.

The SH&WB department undertakes both pre-employment and employment fitness for work assessments. It also provides an immunisation/screening programme to ensure staff are protected against infectious diseases in line with Department of Health guidance.

The service continues to support the Trust with the management of sickness absence and providing advice in relation to health conditions which may have an impact upon an individual's health at work or vice versa, providing a face to face counselling service for psychological support. Following the approval of the Trust's first health and wellbeing strategy in 2016/17, several key achievements were delivered in 2017/18. Following a staff physiotherapy pilot undertaken to act as an early intervention service for colleagues suffering with musculoskeletal complaints, the service has been overwhelmingly well received by colleagues and helped many to return to work sooner than they would have done without such intervention.

The health and wellbeing steering group was constituted to oversee the project management activity for the Trust on a monthly basis, led by our head of health and wellbeing with quarterly reporting to the overarching senior workforce board and also to the sub-Trust Board, NED chaired, workforce and development assurance committee.

The group has enlisted some critical friends to support its work – head of communications, hospital chaplain, service managers, divisional HRBPs, community providers. Via the steering group, colleagues have been committed to actions and supporting our cause to great effect.

Evaluation of the impact of SH&WB activity was gleaned through a number of routes, such as Pulse surveys using Staff Friends and Family Test. The Trust has used various means of communicating developments (payslip attachments, email, health and wellbeing events, quarterly newsletter, workforce website). Weekly uptake of flu vaccinations was reported on a weekly basis to the executive team and socialised with the Trust via the CEO weekly newsletter (jab-o-meter). For the second successive year, the Trust achieved the flu vaccination target in 2017/18, vaccinating over 78% of front line MKUH colleagues and commenced a series of monthly activities in support of education and prevention.

The department's staff health and wellbeing co-ordinator, Claire Hobbs, was awarded the Trust's Rising Star Award in 2017/18 in recognition of her achievements in driving the success of the service. The Trust's 2017 staff survey results confirm that it has made great strides in improving the health and wellbeing of our organisation; a 10% increase in staff reporting that the trust takes positive action on health and wellbeing since the 2016 survey – up to 39% in 2017.

Critical to our health and wellbeing agenda, the strategy sets out our intent to engage with partners to ensure that the wellbeing of our workforce underpins excellent performance through education, prevention and effective management of health conditions.

2.8.8 Staff Survey Results

The 2017 national staff survey was undertaken between October and December 2017. For the third year running, the Trust selected the market leader in the analysis of staff survey results, Picker, to administer its survey and undertake analysis on its behalf, providing the results for use by the Care Quality Commission (CQC) in their benchmark reports.

2017's survey was MKUH's third successive full census; enabling a rich and valuable return in terms of both quality and quantity.

1430 colleagues returned their completed survey within the deadline requirement; a response rate of 43%, which is average for acute Trusts in England. It compares with 45% (n=1434) in 2016, 50% (n=1517) in 2015 and 49% in 2014 (sample based survey; 378 returns). A variety of methods were used to encourage returns, including regular communications with staff, publicity at meetings, monitoring and chasing of non-return areas and a prize draw.

NHS Staff Survey 2017 - Summary of Performance

The Trust's staff engagement score remained consistent with its 2016 level. The five key findings for which MKUH compares most favourably with other acute trusts are:

- KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month – MKUH = 94%, national average for acute trusts = 90%
- KF24. Percentage of staff / colleagues reporting most recent experience of violence – MKUH = 76%, national average for acute trusts = 66%
- KF19. Organisation and management interest in and action on health and wellbeing – MKUH = 3.77, national average for acute trusts = 3.62
- KF13. Quality of non-mandatory training, learning or development – MKUH = 4.12, national average for acute trusts = 4.05
- KF2. Staff satisfaction with the quality of work and care they are able to deliver – MKUH = 3.98, national average for acute trusts = 3.91

The five key findings for which MKUH compares least favourably with other acute Trusts are:

- KF23. Percentage of staff experiencing physical violence from staff in last 12 months – MKUH = 4%, national average for acute trusts = 2% (MKUH was 3% in 2016, 4% in 2015)
- KF16. Percentage of staff working extra hours – MKUH = 77%, national average for acute trusts = 72% (75% in 2016 and 2015)
- KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves – MKUH = 57%, national average for acute trusts = 52% (Improved from 65% in 2016 and 67% in 2015)
- KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month – MKUH = 33%, national average for acute trusts = 31%
- KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months – MKUH = 18%, national average for acute trusts = 15%

Overall the results were in the top 20% of acute Trusts for 13% of the survey's outcomes, in the following areas:

- Quality of non-mandatory training, learning or development
- Staff reporting errors, near misses or incidents witnessed in the last month
- Organisation and management interest in and action on health and wellbeing
- % reporting most recent experience of violence

NHS Staff Survey Results 2017

Response Rate	2016	2017	Benchmarking group (acute trusts)	Trust improvement / deterioration
	45%	**43%**	**434%**	**Decrease of 2%**

Top 5 ranking scores	2016 Trust	2017 Trust	2017 Benchmarking group (acute trusts)	Trust improvement / deterioration
KF27:Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	91%	**94%**	**90%**	**Improvement of 3%**
KF24: Percentage of staff/colleagues reporting most recent experience of violence	71%	**76%**	**66%**	**Improvement of 5%**
KF28: Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	3.55	**3.77**	**3.62**	**Improvement of 0.22**
KF29: Percentage of staff reporting errors, near misses or incidents witnessed in the last month	4.02	**4.12**	**4.05**	**Improvement of 0.10**
KF2: Staff satisfaction with the quality of work and care that they are able to deliver	3.98	**3.98**	**3.91**	**No change**

Bottom 5 ranking scores	2016 Trust	2017 Trust	2017 Benchmarking group (acute trusts)	Trust improvement / deterioration
KF23: Percentage of staff experiencing physical violence from staff in last 12 months	3%	**4%**	**2%**	**Deterioration of 1%**
KF16: Percentage of staff working extra hours	75%	**77%**	**72%**	**Deterioration of 2%**
KF18: Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	65%	**57%**	**52%**	**Improvement of 8%**
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	30%	**33%**	**31%**	**Deterioration of 3%**
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	16%	**18%**	**15%**	**Deterioration of 2%**

The Trust's staff survey results have remained largely static since 2016 but they have deteriorated compared to other acute Trusts. However, it is clear that our interventions need to have greater impact with staff in order that more positive returns are reflected in the 2018 staff survey. This will also be a census, in line with the NHS England mandate.

The Trust has developed a comprehensive staff survey action plan since receipt of the 2013 survey outcomes. This encompasses the themes that have been highlighted since 2014 in order that this work is not undertaken in isolation and that it takes into account organisational development and associated longer term shifts in culture.

The corporate action plan has been revised for 2018 with a view to addressing the areas of concern raised in the survey and, concurrently, to continue to support its positive outcomes. This will link to wider organisational development work such as the 'Event in the Tent 2' and the Trust's equality, diversity and inclusion programme. Benchmarking has also been undertaken across the BLMK STP and the Midlands and East region in order to target system-wide interventions and sharing of best practice across the regional NHS and local government settings.

Led in the clinical divisions by the HR business partners, there will be wide communication of the results to managers and staff, with a view to developing divisional plans to address the areas of concern/underperformance. The Trust will seek to use both modern and traditional means of communication (such as the workforce website, social media, presentations and engagement events).

Working in partnership with our staff side colleagues, the results and action plans will also be developed and shared with our Joint Consultation and Negotiation Committee (JCNC), Joint Local Negotiating Committee (JLNC) partners.

The action plan will be actively monitored through Workforce Board on a monthly basis with an interim update report to the Trust's Management Board in July 2018 and a final report to the Management Board in October 2018, to coincide with the issue of the 2018 survey in October – December 2018.

Key areas for improvement arising from the 2018 staff survey are:

- Reduce the percentage of staff experiencing physical violence from staff AND patients, relatives or the public in last 12 months.
- Reduce the percentage of staff working extra hours.
- Reduce the percentage of staff attending work in the last 3 months despite feeling unwell because they felt. pressure from their manager, colleagues or themselves
- Reduce the percentage of staff witnessing potentially harmful errors, near misses or incidents in last month.
- Key findings relating to staff health and wellbeing, retention and experience.

2.8.9 Off-payroll Engagements

The Trust has not engaged any off-payroll arrangements in 2017/18.

Table 1: For all off-payroll engagements as of 31 Mar 2018, for more than £245 per day and that last for longer than six months	**2017/18** Number of engagements
No. of existing engagements as of 31 Mar 2018	0
OF WHICH:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached	**2017/18** Number of engagements
Number of new engagements, or those that reached six months in duration, between 01 Apr 2017 and 31 Mar 2018	0
OF WHICH:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2017 and 31 Mar 2018	**2017/18** Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	18

The Trust has a policy of using its own payroll for the purposes of employment. Where engagement is required that is off-payroll, this is facilitated through national framework agency providers only. In the event that any further off-payroll arrangements are required, the Trust uses a comprehensive risk assessment form and the HMRC personal service company assessment tool which both seek to test the nature of the engagement, whether the individual is aware of their obligations in respect of payment of tax and require them to provide assurances in this regard before they are engaged. Following completion of the risk assessment, approval is sought of the director of finance and director of workforce in order to finalise the arrangement.

2.8.10 Exit packages

No exit packages have been agreed by the Trust in 2017/18, whether through compulsory redundancy, voluntary redundancy, or any other type of agreed exit package.

2.8.11 Workforce Strategy (2014 to 2018)

The workforce strategy sets out the strategic framework for the MKUH workforce and was approved in 2014. On an annual basis, objectives for the year ahead are agreed with Trust Board, in line with the workforce strategy, with time bound activities to support their delivery.

The aim of the strategy is to develop a flexible, skilled and motivated workforce which has the competencies, capacity and capability, alongside demonstrable behaviours in line with the Trust values, to meet the Trust's objectives and future challenges. It is underpinned by a series of annual workforce, organisational development, education and training plans.

The strategy recognises the culture of the Trust, how it is led and how it recruits and retains staff, building on the progress of the WeCare programme, to ensure we deliver the highest possible care to our patients.

Work has commenced to review the workforce strategy, which ends in 2018. The Trust's workforce board has approved the initial direction which is focused on improving staff experience of #TeamMKUH in order to continue to improve patient experience, quality and safety outcomes. In 2017, a new recruitment strategy was also approved to underpin the workforce strategy. This will be supported by a dedicated retention strategy in 2018 as the trust seeks to improve the stability and decrease turnover levels of its workforce.

2.8.12 Equality and Diversity

The Trust has a longstanding commitment to ensuring that our services and employment practices are fair, accessible and appropriate for all patients, visitors and carers in the community we serve, as well as the talented and diverse workforce we employ. The Trust board receives a comprehensive annual report of equality and diversity information, the last of which was in 2017.

The Trust remains committed to providing an environment equally welcoming to people of all backgrounds, cultures, nationalities and religions. Our 'We Care' standards, behaviours and commitments help us to achieve this aim.

The executive workforce lead and the patient services lead for equality and diversity are both members of the Workforce and Development Assurance Committee which is responsible for overseeing equality and diversity for the Trust.

Supporting the local staff survey outcomes, regional and national requirements (workforce race equality standard and equality delivery system 2) and public sector duties of the Equality Act 2011, an equality, diversity and inclusion forum was established in 2015 which oversees matters in this sphere of activity and acts as a steering group for both our workforce and patient care and experience. Engagement with Milton Keynes Council and Milton Keynes CCG has been built into the terms of reference of the group and mutual benefits have already resulted from our approach in this regard.

Key pieces of work undertaken in 2017 include; achievement of the Employer standard for the government's Disability Confident scheme, an organisational assessment of the workforce disability equality standard (WDES) and the commencement of Pride@MKUH; the trust's first lesbian, gay, bisexual, transgender and other (LGBT+) forum. In line with statute, the Trust also collated and published its Gender Pay Gap data report in support of improvement. The equality, diversity and inclusion agenda of the Trust supports all of the protected characteristics and is recognised as being critical to retention and the experience of our staff.

2.8.13 Workforce Resourcing

The Trust has developed and delivered a number of key initiatives and activities to support the recruitment and retention of its workforce over the course of the past year, including:

- Implementation of the new junior doctor contract and supporting rotations to ensure that medical staffing contractual compliance, skill mix, support and education is timely and appropriate.
- Refinement and improved visibility of recruitment metrics to monitor activity and areas for improvement.
- Introduced enhanced recruitment and retention premia for 'hard to recruit and/or retain' posts.
- Introduced enhanced bank rates in critical areas in order to reduce reliance on high cost agency alternatives.
- Improved vacancy and temporary staffing requests and management information systems in order to ensure compliance with NHS Improvement agency rules and weekly reporting obligations.
- Developed a workforce website across multiple platforms to support recruitment, retention, education and learning and medical education.
- Collaboration with the East Midlands NHS streamlining recruitment network to improve time to hire and reduce resourcing inefficiency.
- Enhanced use of social media to increase visibility and reach of our recruitment campaigns, open days and the #TeamMKUH brand.

Furthermore, the approval of the Trust's first recruitment strategy enables the Trust to position itself uniquely in the context of a highly competitive regional employer's market and strive for further enhancements to the Trust's reputation as an employer of choice.

Through a sustained programme of improvement, the temporary staffing function has supported a number of actions within its function in 2017, enabling the Trust to achieve its agency ceiling financial target for much of the year through; improved use of the e-rostering system, extended hours working (weekends and bank holidays), reduced agency rates for nursing and midwifery agency colleagues and weekly paid internal bank.

2.8.14 Learning & Development

- Regular corporate induction has been held throughout 2017/18 to welcome and orientate new colleagues to MKUH. Trust induction is two days for non-clinical colleagues and up to a week for clinical colleagues and includes key information such as Trust values and objectives and MKUH specific information to prepare new starters to be an effective member of the MKUH team. Each induction starts with a personal welcome on the first session on the first day from our Chief Executive who shares the progress that MKUH has made over the years, has a question and answer session and informs of the latest Trust updates.
- The target of 90% compliance in statutory/mandatory training has been maintained throughout the majority of 2017/2018.
- The Trust appraisal compliance rate (as of end of February 2018) is sitting at 85% with just 1 division achieving over 90% compliance (Core Clinical Services).
- End of year 2017/18 expenditure reports have been received from our contracted Universities and we have utilised our received education funding allocation carefully and appropriately. Where possible we have arranged for universities to run clinical modules on-site, which in turn makes them both cost effective and more accessible.
- We continue to run a suite of personal development courses from full Leadership and Management programmes running over several months to shorter personal development offerings.

2.8.15 Participation

- **Work Experience**
  We offer three structured programmes for work experience: a 5-day clinical work experience for 16-18 year olds; a 5-day non-clinical experience for 16-18 year olds; a 2-day Accident and Emergency work experience for those who can demonstrate they are eligible to apply for medical school training

- **Apprenticeships**
  During 2017/18 we have signed up 12 apprenticeships from existing staff and new hires apprenticeship posts. The new Apprenticeship Levy was introduced in May 2017 and this has resulted in a temporary reduction in the number of available apprenticeships while new standards relevant to healthcare are awaited. We continue to work with other Trusts in the area to share information and ensure a consistent approach.

  In March we celebrated National Apprenticeship Week with an event for our apprentices who had completed in the previous year, competitions, training and shadowing events.

  The Trust has maintained the 'Fair Train Bronze Standard'.

- **Working with Schools**
  We have continued to work with charity Worktree, with some Trust staff going into schools to answer questions from students about their NHS career. Worktree have also extended their programme with some staff taking part in Careers Workout sessions with homeless jobseekers.

  We have also started working to take our own careers' events into schools and are excited to inspire our workforce of tomorrow.

- **NHS Management Training Scheme (MTS)**
  The Trust was successful in hosting one MTS Graduate trainee in General Management during 2017/18

  6 applications for placements to be accredited have been submitted to HEE-TV. This is for new MTS trainees to start on placement at the Trust in September 2018.

- **Library Services**
  The Library's literature searching continues to provide detailed evidence-based information which underpins both clinical and management decision-making re changes to services and treatment, as well as supporting the writing and amending of clinical and non-clinical policies within the Trust.

  The Library team also offers support for e-learning for statutory and mandatory training, as well as continuing professional development. The Library team coordinated the provision of the iCare e-learning induction package for Junior Doctors and ensured content was updated to reflect current hospital guidance and procedures. Staff also negotiated contracts for a point of need tool UptoDate. New in-house modules for Dementia and Diabetes have also been developed in collaboration with clinical staff.

  In addition a range of new leaflets has been produced, the first series to support the management and leadership courses arranged by Learning and Development; and a second series to promote staff health and wellbeing have been produced containing information about books, apps and websites; topics covered include mindfulness, sleep, giving up smoking, relaxation, stress,

2.9 Medical Education

2.9.1 Undergraduate Education

- **University of Buckingham Medical School**
  The Trust is now running the two clinical years of the medical school curriculum named Junior and Senior rotation. This sees students based in more clinical areas working with multidisciplinary teams across the hospital. We now have clinical blocks in MSK, Peri-operative, Cardio-respiratory, Gastro, Special senses, Cancer Care, Acute Care, Child Health, Reproductive Medicine and Elderly Care.

  The increase in workload has meant that the undergraduate administration team has increased to 6 WTE's.

- **The Academic Centre**
  The new Academic Centre was officially opened on the 20th February 2018, currently the building is housing all of the educational activity for the medical students along with exams and OSCE's.

- **Simulation Team**
  The Simulation team has also increased in size due to the requirements to deliver the UOB curriculum, the team now consists of a Band 7 Manager, 2 Band 6 Practitioners, band 4 AV technician and a band 3 technician. These posts have been recruited to and we are awaiting the start dates of three of the new team.

2.9.2 Post Graduate Medical Education

- **HEETV (Health Education Thames Valley)**
  On 31st January 2018 we had a visit from the Quality Team from HEETV to revisit the situation in Cardiology with regards to our SPR training posts. We had our Registrar training posts removed from August 2015 due to concerns from HEETV that trainees were not gaining adequate training to be able to get signed off as expected. The team returned from HEETV in January and met with the Trust team and a decision was made to reinstate these posts, potentially from August 2018, but this will depend on numbers of trainees in the region due to rotate. This was a fantastic achievement from the department; Dr Cliona Kenny was a key person in this process.

- **HORUS**
  A new e-portfolio platform named Horus was launched for HEETV Foundation trainees from August 2017. There were many teething problems with the programme initially with trainees unable to access certain areas on the system mainly around assessments. But now things have settled and trainees and Supervisors are enjoying using the new platform. Our department offers overview sessions for new users to the system to familiarise people with its workings and uses.

- **Modular Ultra Sound ESTES Course MUSEC**
  This course is jointly run with Trust doctors and other European doctors from Spain and Italy. We have run 4 courses for our Trust doctors and external participants who pay to attend. It has been successful and it is intended that the course will continue to run. The course provides an opportunity where undergraduate students (from both Oxford and Buckingham medical schools) participate as models but also benefit from the training even before they graduate as doctors.
- **Keele Leadership Programme**
  The Trust will be working in partnership with Keele University to provide a 3 day course in Clinical Leadership and management, for all trainee doctors in the Trust, in June and July 2018.
- **Training for SAS doctors**
  Two courses were run for our SAS doctors at Kents Hill and at the Lecture theatre, Certificate of eligibility for specialist registration (CESR). Further development programmes for SAS doctors are being planned for later this year.
- **New Consultant development programme**
  The new consultant development programme continues to be run successfully. The New Consultant Development programme is designed to meet the needs of all newly appointed consultants. The programme focuses on development of leadership capabilities as well as increase consultant's knowledge of in health care systems outside of their clinical role. Cohort 3 will start their course on 22 March 2018 and 2019 for cohort 4.
- **Induction for new doctors/foundation doctors**
  Inductions for junior doctors occur yearly in January, February, August and October for all junior doctors and July for Foundation year doctors.

  In August 2017, the Trust inducted more than 70 doctors who started their rotations in several specialities. The feedback from the doctors on the induction programme was positive.

  Planning for this year's July and August inductions have commenced with focus on all lessons learnt from last year's induction, to ensure doctors' experience during their induction continues to be good.


Pharmacy
NHS

2.10 Organisational Development (OD)

The Trust has an overarching organisational development Programme called "We Care" which seeks to influence the culture of the organisation, through interventions which improve staff wellbeing and engagement and patient experience, by embedding the Trust values and by modelling positive behaviours consistently.

- **Schwartz Rounds**
  Schwartz Rounds are multi-disciplinary forums designed for staff to come together once a month to discuss and reflect on the non-clinical aspects of caring for patients i.e. the emotional and social challenges associated with their jobs. In 2017-2018 there were 5 Rounds and 3 team away day rounds. Since 2016 there have been 14 Rounds held and over 500 staff have attended. Staff who regularly attend Schwartz Rounds to share the emotional, ethical and social challenges they face in the workplace experience less psychological distress, improved team working and increased empathy and compassion for patients and colleagues.
- **Long Service Awards**
  Our long service awards ceremony was held on the 25 August 2017 recognising 43 colleagues who had worked at the Trust for over 25 years. Recipients and their guests attended the event with the Trust's executive team. Each staff member received a framed certificate signed by the CEO, a paperweight that represented their years of service at the Trust and a gold (30 years) or silver (25 years) name badge. This was then followed by afternoon tea.
- **P2P Peer to Peer**
  The P2P listening service is well embedded within the Trust. The P2P listening service aims to provide a space for colleagues to share and offload things which they are struggling with, either within their work or outside. There are 44 active trained P2P volunteers which is more than 1% of the workforce. In 2016-2017 the P2P listening service had contact with 619 people and 47% of the conversations were work related. In the first quarter of 2017-18, 207 members of staff contacted the service and of those 25% were work related. The aim for 2018/2019 is to ensure that staff remain aware of the service, to continually recruit a sustainable number of volunteers and to ensure that every member of #Team MKUH feels supported and cared for.
- **Coaching**

  The Trust has developed a Coaching service for staff, with a Lead Coach and a cohort of 6 Coaches currently completing a qualification, and 6 more about to be recruited. The Coaching service is open to all staff and is usually conducted in 4-6 one-hour sessions. So far 25 people have benefited from coaching to help them in their career.

2.11 Volunteers

Milton Keynes University Hospital NHS Foundation Trust has over 275 volunteers who enhance the experience of patients, visitors and staff. Our teams of volunteers make a positive impact on the care that the hospital delivers, and have supported the Trust during 2017/18 by giving over 50,000 hours of their time.

2.12 Code of Governance disclosures

Monitor Code of Governance

Milton Keynes University Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors considers that it was compliant with the provisions of the revised Monitor NHS Foundation Trust Code of Governance, with the following three exceptions:

Provision	Explanation for non-compliance
A.5.6 The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns.	The Council of Governors raise concerns at their regular meetings which members of the Board of Directors attend. In addition, the lead governor meets with the chairman and can raise issues on behalf of the Council. The senior independent director also meets informally with governors to discuss issues and governors can raise concerns through these meetings.
B2.4 The chairman or an independent non-executive director should chair the nominations committee.	The Council of Governors believe that the Non-Executive Director appointment committee (formally the Nominations Committee) should be chaired by a member of the Council of Governors, as the Council of Governors has a responsibility for the appointment of Non-Executive Directors. This has been in effect since 2008/9 and is reflected in the Trust's Constitution.
B2.9 An independent external adviser should not be a member of or vote on the nominations committee(s)	The Nominations Committee has always valued the input of the independent external adviser, particularly as the Trust has usually selected a serving Chair or non-executive director of another Trust to act in this capacity.

As per 'The NHS Foundation Trust Code of Governance' (updated July 2014), 'the board of directors is a unitary board. This means that within the board of directors, the non-executive directors and executive directors make decisions as a single group and share the same responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.'

2.13 Single oversight framework

NHS Improvement's single oversight framework provides the framework for overseeing providers and identifying potential support needs.

The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support, and 1 reflects providers with maximum autonomy. A foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

2.14 Segmentation

As of April 2018, the Trust is in segment 2. Current segmentation information for NHS Trusts and foundation Trusts is published on the NHS Improvement website.

2.15 Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the single oversight framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	Year End 2017/18	Year End 2016/17
Financial sustainability	Capital service capacity	**4**	4
	Liquidity	**4**	4
Financial efficiency	Income and expenditure margin	**4**	4
Financial controls	Distance from financial plan	**1**	1
	Agency spend	**1**	2
Overall Scores		**3**	**3**

2.16 Statement of the chief executive's responsibilities as the Accounting Officer of Milton Keynes University Hospital NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

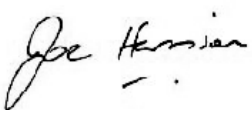
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Milton Keynes University Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Milton Keynes University Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.



Joe Harrison
CHIEF EXECUTIVE

Date: 25 May 2018

2.17 Annual Governance Statement

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Milton Keynes University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Milton Keynes University Hospital NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Leadership of the risk management process:

Board of Directors

The Board of Directors (Board) has overall responsibility for the identification and effective management of principle risks to the achievement of the Trust's strategic objectives. These risks are captured on and managed through the Board Assurance Framework (BAF). The Trust has ten primary strategic objectives; namely:

1. Improving patient safety
2. Improving patient experience
3. Improving clinical effectiveness
4. Deliver key targets
5. Develop a robust and sustainable future
6. Develop robust and innovative teaching and research
7. Become well-governed and financially viable
8. Improve workforce effectiveness
9. Make the best of the estate
10. Develop as a good corporate citizen

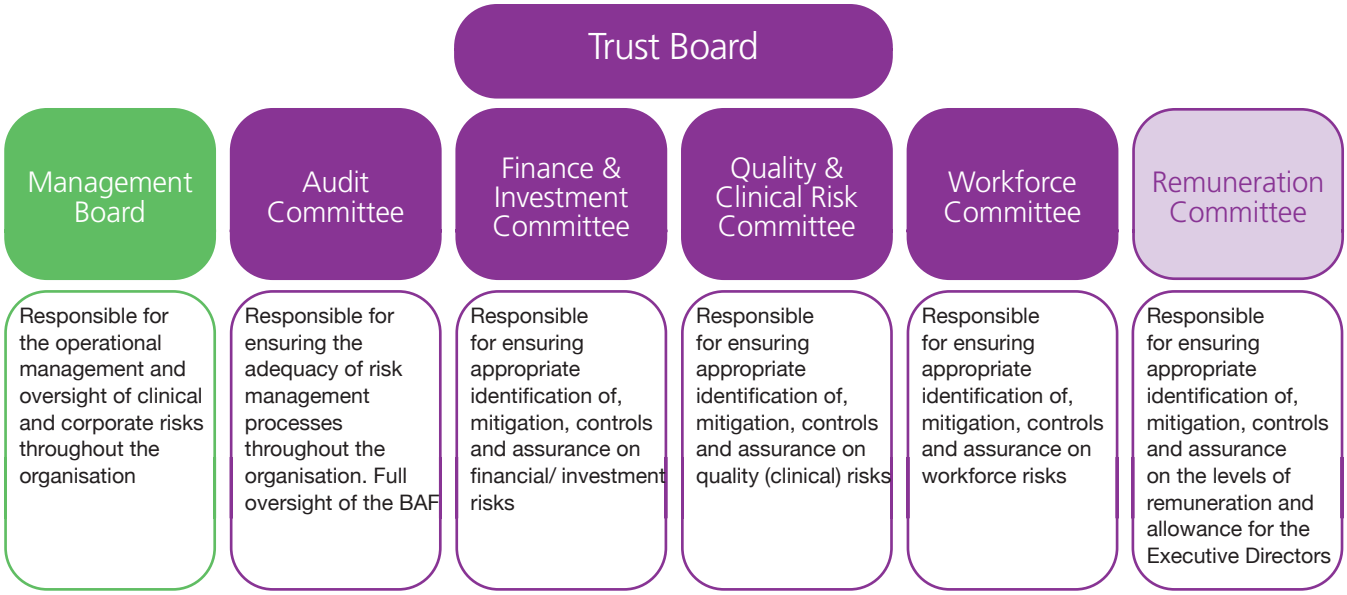
The breadth of these objectives mean that the BAF contains a broad spectrum of risks of which the Board has oversight.

Board Sub Committees
The Board delegates the testing of assurance and management controls on the BAF to its Sub Committees.

Each Committee is responsible for risks to the achievement of objectives within its terms of reference.

In addition, the Quality and Clinical Risk Committee has a wider oversight role on the effective management of clinical risk.

The Audit Committee has a wider oversight role on the effective management of corporate risk and provides assurance to the Board on the adequacy of the systems and processes surrounding the management of risk throughout the organization as a whole.



Executive Leadership and Management Oversight
The Director of Corporate Affairs is the executive lead for risk management. The Trust's Senior Information Risk Owner (SIRO) is the Deputy Chief Executive, who is responsible for, and oversees all information risks within the Trust. The Trust's Caldicott Guardian is the Medical Director, who is ultimately responsible for the correct use of patient identifiable information. Both the SIRO and the Caldicott Guardian have undertaken the required training to discharge their responsibilities effectively.

All directors and divisional managers have a leadership responsibility for risk management within their own areas and are accountable to the trust Board via general and specific reports.

The Trust has established a Risk and Compliance Board (RCB) which meets monthly and is chaired by the Director of Corporate Affairs. The RCB reviews risks rated 15 and above on the significant risk register (SRR). It challenges the control measures and actions being taken; assesses risk score; approves corporate risks; reviews linked risks across specialties/ departments and divisions; reviews the aggregated risk profile; and reports each month to the Management Board.

Divisional and departmental risk registers are also reviewed on a rotational basis to ensure that the risks are relevant and appropriate; that risks are being effectively identified, assessed, mitigated and managed. The RCB receives reports on the number of overdue incidents, audit compliance, trust documentation and reports on other compliance reports e.g. CQC/ regulatory guidelines and NICE guidelines, NCEPOD, and other relevant statutory, legislative, or regulatory compliance requirements or guidance.

Equipping and Training Staff to Manage Risk and Learning from Good Practice

Equipping and Training Staff to Manage Risk

The identification, assessment and management of risk is the responsibility of all staff. The Trust's mandatory training programme, which forms part of the staff induction, includes responsibilities and processes relating to risk management which encompasses fire safety, health and safety and clinical risk. Levels of compliance with mandatory training are reported to the Board as part of the monthly performance dashboard. Further guidance on risk management issues is disseminated to staff through briefing systems either electronically including the intranet or via meetings.

Learning from Good Practice

The Trust's central risk management team work effectively with the Trust's internal auditors to continually challenge and improve risk management processes as part of the annual development and audit programme. The central risk team holds regular dedicated sessions on improving practice; using external reports on good practice and industry recommendations to facilitate ongoing improvements to risk management. This includes and involves divisional risk and governance leads.

Organisationally, good practice and learning identified through risk assessments and incidents is shared through routine communications, training, meetings, briefing and de-briefing sessions and committees. A standardised learning audit cycle is being introduced to ensure recommendations to changes in practice or policy are sustained.

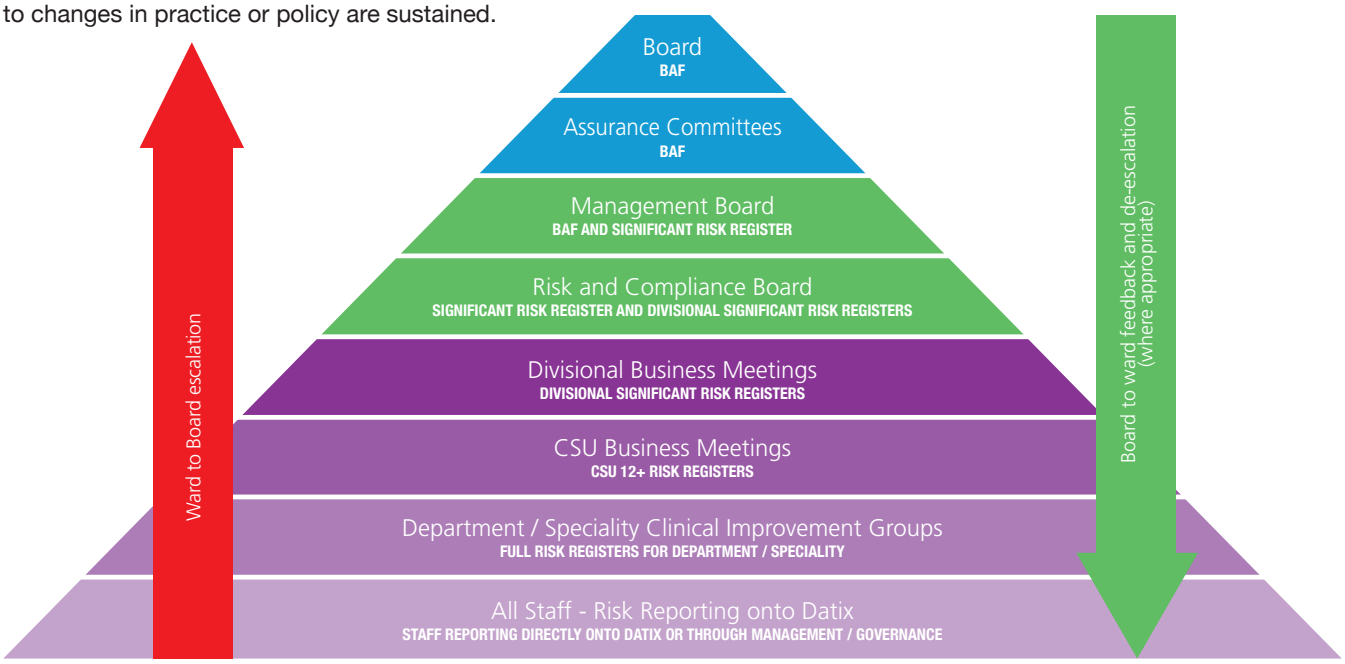
The Risk and Control Framework

Risk Management Strategy

Risk management is an integral part of the Trust's management, governance structure and internal control processes. It is the process through which the Trust identifies, assesses and analyses the risks inherent to and arising from its activities; whether clinical or non-clinical, including strategic, financial, workforce or any other; and ensures robust and effective controls and assurances are in place.

The Trust has a Risk Management Strategy, which sets out a delegated governance structure through which risks are monitored and managed. It sets out a systematic process for the identification, recording and management of risk through its specialty, divisional and significant risk registers and clearly defines the escalation and de-escalation of risk as detailed in the diagram below.

The Risk Management Strategy sets out how risk appetite is determined, with the Board of Directors setting risk appetite against the Trust's ten strategic objectives during annual risk appetite development and review.



Quality Governance Arrangements

The Trust operates within the NHS Foundation Trust statutory and regulatory environment and its quality governance arrangements are regularly reviewed to ensure compliance with relevant regulatory (and other legal or professional) standards. This includes the NHS Improvement and Care Quality Commission combined Well-Led Framework. The Trust has undertaken a self-assessment against the Well Led Framework within the reporting period.

The Trust has a well-defined quality governance structure in place, designed to provide 'ward to Board' visibility, reporting and assurance across the quality agenda.

The executive and the Trust Board seek information and assurance on compliance. Improvements in the reporting period include an assurance rating against performance information reported to the Board, based on data quality confidence levels. The Trust also has an established Data Quality Compliance Board to provide scrutiny, challenge and assurance on all aspects of data quality which reports to the Audit Committee.

The Trust ensures compliance with CQC registration requirements is monitored and assessed through its governance structure. This includes compliance monitoring at the Risk and Compliance Board; proactive assessment through the Clinical Quality Board and Nursing and Midwifery Board; proactive assessment through the clinical divisional management; and independent peer review (e.g. Healthwatch enter and view). Compliance is assured through the Quality and Clinical Risk Committee.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Board has sought assurance on the management of risks to data security, with reports and presentations to the Audit Committee and to the Board during 2017/18. Data security (compromise through deliberate attack; and breach through inadequate controls) are risks on the Board Assurance Framework which are actively monitored and assurance-assessed through the Board sub-committees.

Major Risks

The Board Assurance Framework reflects the principle risks against the achievement of the Trust's strategic objectives, including clinical and non-clinical risk. The following risks were identified on the Board Assurance Framework at the end of the 2017/18 financial year. The table shows the scores as agreed by the Board and its Committees as at January and April 2018. The movement in some of the scores illustrates the live nature of the document and captures both the specific actions that have been taken to mitigate the risks as well as the impact that other events have had. In relation to risk 4-3, for example, there has been recognition both by the Audit Committee and the Trust's internal auditors, of the significant improvements that have been made on data quality. The change to the rating of risk 7-5 on the other hand reflects the fact that the Trust was ultimately able to access funding.

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)	
					Jan-18	Apr-18
SO1: Patient Safety	1-1	Quality & Clinical Risk	Strategic failure to manage demand for emergency care	Next 3 - 6 months	Not on BAF	(4x3) = 12
SO1: Patient Safety	1-2	Quality & Clinical Risk	Tactical failure to manage demand for emergency care	Next 3 - 6 months	Not on BAF	(4x3) = 12
SO1: Patient Safety	1-3	Quality & Clinical Risk	Ability to maintain patient safety during periods of overwhelming demand	Next 3 - 6 months	(4x5) = 20	(4x4) = 16
SO1: Patient Safety	1-4	Quality & Clinical Risk	Failure to appropriately embed learning and preventative measures following Serious Incidents	Next 3 - 6 months	(5x2) = 10	(5x2) = 10
SO1: Patient Safety	1-5	Quality & Clinical Risk	Failure to recognise and respond to the deteriorating patient	Next 3 - 6 months	(4x3) = 12	(3x3) = 9
SO1: Patient Safety	1-6	Quality & Clinical Risk	Failure to manage clinical risks through the implementation of eCARE (go-live)	Next 3 - 6 months	Not on BAF	(4x3) = 12
SO2: Patient Experience	2-1	Quality & Clinical Risk	Failure to provide an appropriate patient experience	Next 3 - 6 months	(4x4) = 16	(4x4) = 16
SO3: Clinical Effectiveness	3-1	Quality & Clinical Risk	Lack of assessment against and compliance with best evidence based clinical practice through clinical audit	Next 3 - 6 months	(4x3) = 12	(4x3) = 12
SO3: Clinical Effectiveness	3-2	Quality & Clinical Risk	Lack of assessment against and compliance with NICE guidance	Next 3 - 6 months	(4x3) = 12	(4x3) = 12
SO4: Key Targets	4-1	Management Board	Failure to meet the 4 hour emergency access standard	Next 3 - 6 months	(4x5) =20	(4x4) =16
SO4: Key Targets	4-2	Management Board	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	Next 3 - 6 months	(4x3) = 12	(4x3) = 12
SO5: Sustainability	4-3	Audit	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Next 3 - 6 months	(4x5) = 20	(4x3) = 12
SO5: Sustainability	5-1	Finance	Failure to adequately safeguard against major IT system failure (deliberate attack)	Next 3 - 6 months	(3x3) = 9	(5x2) = 10
SO5: Sustainability	5-2	Finance	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Next 3 - 6 months	(3x3) = 9	(4x2) = 8
SO5: Sustainability	5-3	Management Board	Failure to successfully deploy EPR in a way that diminishes disruption	Next 3 - 6 months	(5x3)=15	(4x3) = 12
SO5: Sustainability	5-4	Management Board	Failure to maximise the benefits of EPR	Next 3 - 6 months	(4x3) = 12	Reassessment required
SO7: Finance and Governance	7-1	Finance	Inability to keep to affordable levels of agency and locum staffing	Next 3 - 6 months	(5x4)=20	(4x3) = 12
SO7: Finance and Governance	7-2	Finance	Timing and release of capital and revenue funding	Next 12 months	(5x5) = 25	(4x4) = 16
SO7: Finance and Governance	7-3	Finance	Inability to achieve the required levels of financial efficiency within the Transformation Programme	Next 12 months	(5x4) = 20	(4x4) = 16

Strategic Objective	Risk Ref	Committee	Risk Description	Proximity	Risk Score (consequence v likelihood)	
					Jan-18	Apr-18
SO7: Finance and Governance	7-4	Finance	Disagreement with main commissioner over the level of performance that they are prepared to fund	Next 12 months	(5x4) =20	(4x4) = 16
SO7: Finance and Governance	7-5	Finance	The Trust is unable to access £7.3m of Sustainability & Transformation Funding	Next 3 - 6 months	(5x5) = 25	(4x4) = 16
SO7: Finance and Governance	7-6	Finance	The Trust fails to utilise available capital funding according to strategic and clinical priorities	Next 12 months	(3x4) = 12	Reassessment required
SO7: Finance and Governance	7-7	Finance	Failures in compliance leading to regulatory intervention (CQC)	Next 12 months	(4x3) = 12	(4x3) = 12
SO8: Workforce	8-1	Workforce	Inability to recruit to critical vacancies	Next 3 - 6 months	(4x4) = 16	(4x3) = 12
SO8: Workforce	8-2	Workforce	Inability to retain staff employed in critical positions	Next 3 - 6 months	(4x3) = 12	(4x3) = 12
SO10: Corporate Citizen	9-1	Charitable Funds	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Next 3 - 6 months	(4x3) = 12	(4x3) = 12
SO10: Corporate Citizen	10-1	Board	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Next 3 - 6 months	(4x3) = 12	(4x3) = 12

Detailed information on how risks are controlled (mitigated) and the assurance against the controls is contained within the Board Assurance Framework. This document is actively scrutinized in every Board sub-Committee and at the Board (every quarter). The Board holds a minimum of two risk and assurance plenary sessions every year to enable risk appetite to be effectively reviewed and assessed and for principle risks against the achievement of the Trust's strategic objectives to be assessed and reviewed holistically. This includes risks to compliance with the Trust's licence; and compliance assessments and risks are also embedded in Board reporting. The Board formally reviews compliance against its licence during its annual declarations and in line with statutory and regulatory requirements. The Trust self certifies against the Corporate Governance Statement, required under NHS Foundation Trust Condition 4 (8)(b) based on information and assurance received at the Board and its sub-Committees.

Every principal risk has an executive risk owner, responsible for the active and ongoing management of that risk; including assessment of risk likelihood and severity (5x5 matrix), proximity, controls, assurance of controls (three lines of defence) and additional mitigating actions required. The executive director presents the risks they take ownership for at the relevant Board sub-Committee (all risks are assigned to a sub-Committee). The sub-Committee chair includes his/ her views on assurance and any matters for escalation to the Board in the upward report from the sub-Committee to the Board. The Board then reviews both the sub-Committee reports on risk; the Board Assurance Framework and corporate risk profile and is able to challenge executive risk owners at each meeting.

Incident Reporting

In addition to the framework for risk management; the Trust places a strong emphasis on incident reporting; evidenced through a year-on-year improvement in the percentage of staff feeling confident to report incidents. The Trust has a Serious Incident Review Group, which meets weekly, to provide objective review of potential serious incidents and moderate harm incidents. The Trust has also established 'summits' for falls and pressure ulcers to ensure rapid dissemination of learning and understanding of causal or contributory factors. This is embedded in the Trust's governance structure; reporting upwards to Board sub-Committees (Executive Management Board; Quality and Clinical Risk Committee) and to the Board; and downwards through the divisional and clinical specialty unit structures to ensure appropriate briefing and learning.

Stakeholder Involvement in Risk Management

The Trust recognises that effective risk management relies on contributions from outside the organisation as well as from within, and there are therefore arrangements in place to work collaboratively with key external stakeholders and partner organisations, including Milton Keynes CCG, Milton Keynes Council and the local Healthwatch Milton Keynes. The Trust also contributes to the identification and management of risk in the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Partnership footprint. These arrangements cover operational and strategic issues such as service planning and commissioning, performance management and scrutiny, research, education and clinical governance. Commentary and issues arising from this engagement are captured within the Trust's risk processes and taken into account in the risk grading matrix referred to above.

These and other stakeholders have opportunities to raise issues relating to risks which impact upon them, including:

a. Patients and public

- Participation in the "15 steps" process (an assessment of patient areas by patients, non-executive directors and Governors).
- Involvement with and by the Milton Keynes Health and Wellbeing Board.
- Attendance at the Trust's Annual Members' Meeting.
- Structured and ad hoc engagement with and from Healthwatch MK.
- Patient-Led Assessments of the Care Environment (PLACE).
- Representation from Milton Keynes Council, Healthwatch MK, MKCCG and community groups on the Council of Governors.
- Patient stories delivered at Board meetings.

b. Staff

- Messages emerging from the annual staff survey.
- Chief Executive led staff roadshows.
- Questions submitted by members of staff to the Chief Executive via the "Ask Joe" section of the Trust intranet.
- Quarterly staff magazine.
- Annual Event in the Tent.
- Appointment of Freedom to Speak Up Guardians in January 2017 with guardian as a conduit through whom staff may make protected disclosures under the Public Interest Disclosure Act 1998.

c. Health partners

- Regular performance review meetings with the system partners, including other providers, CCGs, GPs, Ambulance Trusts and Local Authorities with whom the Trust has working relationships
- Membership of and involvement on the Maternity Improvement Board with the MKCCG, CQC and NHS Improvement
- Active involvement in the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Partnership, which involves all of the NHS commissioner and provider organisations, as well as local authority social care providers across the three areas.
- Attendance at the Milton Keynes Health and Wellbeing Board.

NHS Pension Scheme
As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality and Diversity
Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with and that equality impact assessments are an embedded part of organisational governance processes.

Sustainability
The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

The Trust's 2007 carbon baseline assessment was 12,747 tonnes per annum, with a target to reduce carbon to 9,559 tonnes by 2014/15.

The following table shows CO2 performance per annum to date

2010/11	11,808 Tonnes
2011/12	11,108 Tonnes
2012/13	11,183 Tonnes
2013/14	10,508 Tonnes
2014/15	9,786 Tonnes
2015/16	9,426 Tonnes
2016/17	9,660 Tonnes
2017/18	10,417 Tonnes (estimated)

The Trust continues to invest in energy saving projects and other carbon reducing schemes to reduce carbon production.

Review of Economy, Efficiency and Effectiveness of the use of Resources

The Trust relies on robust information and data to make informed decisions and is committed to maintaining the highest standards of data quality and effective ongoing management. The Trust is actively engaged with its commissioners in monitoring quality through the contractual relationship, and the achievement of local and national targets is monitored through the use of key performance indicators.

The Director of Finance provides regular reports to the Executive Management Board, Finance and Investment Committee and the Board of Directors on the Trust's current financial position. A similar report is circulated to Board members at Board strategy days.

A range of benchmarking data is provided to the Board to enable constructive challenge of Trust performance. The Board dashboard includes comparative benchmarking data, including from Dr Foster. The Board also reviews its Standing Financial Instructions and Scheme of Delegation annually.

The Trust is clinically-led and this ethos is embedded in its governance and decision-making structure. The Trust has a **Clinical Board Investment Group** (CBIG), which considers and where necessary, challenges proposals, submitted via capital and revenue business cases, for service developments and improvements. It then makes recommendations to the Executive Management Board for these to be approved, amended or rejected. The clinical prioritisation process undertaken by CBIG uses benchmarking data as part of the consideration.

In 2017/18 the transformation programme savings target was £10.5m, of which £9m was delivered. Delivery is overseen by the **Transformation Board**, which meets on a monthly basis to review progress of the programme and reports to the Trust's Executive Management Board and the Finance and Investment Committee following each meeting.

The **Audit Committee** has a key role both as key scrutineer and assurance sub-Committee of the Board and in relation to supporting effectiveness and efficiency across the organisation. It helps to ensure that the work of internal audit is tailored according to the risks and issues facing the organisation, and provides a route by which both internal and external auditors can raise financial and other concerns. It also acts as a conduit between the auditors and the non-executive directors. The chair of the Audit Committee meets with the auditors with no officers present at least once every year, to enable auditors to raise informally any issues that they may have. The Audit Committee also receives quarterly reports from the local counter fraud team, and approves the annual counter-fraud plan.

Internal Audit and Counter Fraud

The Trust's internal auditors are KPMG, who deliver a comprehensive programme of audits every year; including on the financial and wider control environment. Internal audit also supports the Trust in delivering a number of wider assurance and developmental audits throughout the year in an agreed plan. The results of internal audit reviews are reported to the Audit Committee, which takes a close interest in ensuring system weaknesses are addressed. Robust processes are in place to monitor the implementation of improvements identified through audits and to undertake follow up reviews where required. An internal audit tracking system is in place which records progress in implementing recommendations and management responses. Management's progress in implementing corrective action is reported to the Audit Committee. The counter fraud programme is led by the Director of Finance and monitored by the Audit Committee.

Information Governance

The Information Governance Steering Group (IGSG) oversees the Trust's Information Governance Toolkit annual assessment and action plan. Through this governance structure the Trust's Information Governance Statement of Compliance (IGSoC) is assessed on an on-going and annual basis to ensure connection to the NHS National Network (N3) and the use of the NHS Care Records Service applications.

Data security risks are managed through an information governance framework, comprising the Trust's information governance policy, related policies and guidance, and the IGSG. In particular, the Trust's risk management policy sets out a structured approach to information risk management. This involves leadership from the Deputy Chief Executive, who is the organisation's Senior Information Risk Officer (SIRO), as well as individual information asset owners (IAOs) and information asset administrators (IAAs). Information risk identification is supported by the maintenance of an information asset register and regular information mapping exercises. Any significant risks identified from these processes are included in the trust's risk register and will therefore be subject to the formal management attention commensurate with the assessed risk.

The Trust completes the Information Governance Toolkit (IGT) annually to demonstrate that it is meeting good practice requirements, and to provide assurance that all aspects of information risk management are appropriately managed. The IGT assessment is externally reviewed by the Trust's Internal Auditors. The SIRO, along with the Trust's Caldicott Guardian (the Medical Director) and the IGSG monitor progress and compliance with the IGT on an on-going basis. The SIRO and Caldicott Guardian sit on both the Management and Trust Boards.

The Trust operates in a complex environment and exchanges data with a host of external bodies. It therefore takes steps to reduce the risk of data loss or accidental disclosure of personal data. Information governance policy and guidance is continually reviewed and training and awareness raising programmes target all Trust staff. Information governance training includes instruction on and assessment of key aspects of policy and legislation in this area, and assessment scores will indicate the success of awareness raising activities. Strengthened technical controls will result in a reduction of risk of specific types of data loss, for example, privacy impact assessments on all new systems and processes.

The Trust has comprehensive and relevant policies covering information governance and security, data quality and records management.

The Trust has undertaken extensive preparatory work throughout the year in advance of the General Data Protection Regulations (Data Protection Act 2018) which comes into effect as legislation on 25 May 2018. The IGSG has overseen this work programme and reported to the Audit Committee. The Board has also received regular updates and an additional training plenary session on the new legislation and ongoing IG compliance requirements.

Details of information governance serious incidents that occurred during 2017/18 are as follows:

There were a number of reported potential breaches of confidentiality via the Datix system, which were assessed as IG SIRI level 2.

A total of two information governance breaches were reported via the Trust's DATIX incident and risk reporting system.

Incident date	SI Category	Description	Reported to
March 2018	Breack of Confidential Information	Admission letter received by patient with attached theatre list listing 3 different patient full details and procedures.	Information Commissioners Office
March 2018	Breack of Confidential Information	Patient recevied 14 letters in the post. 13 of those letters were intended for other patients, that had been batched into one envelope.	Information Commissioners Office

The Trust has also worked with the Information Commissioner's Office as they pursued the prosecution of a former member of Trust staff for data breaches during that member of staff's employment at the Trust (inappropriately accessed the records of a number of patients outside the requirements of her role). This case was resolved in April 2018 with the former employee pleading guilty to unlawfully accessing personal data and unlawfully disclosing personal data in breach of s55 of the Data Protection Act 1998 at Milton Keynes Magistrates' Court on 20 April. She was ordered to pay £134 for the first offence and £166 for the second offence, plus a victim surcharge of £30.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The following steps are in place to assure the Board that the quality report presents a balanced view and there are appropriate controls in place to ensure that the data produced is accurate.

- The Quality and Clinical Risk Committee has overseen the quality priorities set out in the Quality Account to ensure that they reflect the Trust's priorities. The Audit Committee ensures that the Quality Account complies with NHS Improvement's guidance.
- The Council of Governors has been consulted on the Quality Accounts and has had an opportunity to comment on the quality priorities, including choosing one of them
- Members of the Executive Management Board were given the opportunity to comment on the content Quality Account
- Monitoring key quality metrics at the Executive Management Board and Board of Directors
- Monitoring key national performance indicators relevant to data quality through the national data quality dashboard produced by the NHS Information Centre

Appropriate Controls in Place to Ensure the Accuracy of Data

There is inherent risk in data that is person-reliant. The Trust has undertaken an extensive programme of work over the past two years to continue to strengthen the data control environment and improve data quality, including elective waiting time data.

In 2015/16, the Trust's external auditors had highlighted weaknesses in the Trust's data quality controls during its testing of mandatory and discretionary indicators. As a result, the Trust directed its internal auditors to undertake an audit into its data quality governance arrangements to help inform improvement and development plans and provide assurance on areas of good practice. That audit gave an assurance rating of 'partial assurance with significant improvement opportunities', and proposed four high priority, eight medium priority and two low priority recommendations. In March 2017, the internal auditors reported to the Audit Committee that a significant amount of work had been done with a view to meeting the recommendations, including the establishment of a Data Quality Compliance Board to oversee the implementation of data quality across the Trust, implementing a robust data quality policy, highlighting key roles and responsibilities, and providing details of how data quality will be monitored and managed, and re-focusing the activities of the data quality team. Internal audit undertook a further advisory review of data quality arrangements, which did not have a formal rating, but set out four further priorities to address. Further work within the year has resulted in another advisory report from internal audit commending the work undertaken by the Trust and the much-strengthened governance arrangements for data quality.

Additionally, in the year; a full administrative review of structures and staffing; an extensive training programme; new practices and processes, including new outcome forms. This work has been assessed and assured by the NHS Improvement Intensive Support Team during the year. There is a weekly operational management meeting dedicated to elective waiting list management. The Trust is also rolling out eCARE (Cerner Electronic Patient Record) in May 2018. Data quality remains a risk recorded on the Board Assurance Framework.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and the Quality and Clinical Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process of maintaining and reviewing the effectiveness of the system of internal control during 2017/18 was maintained and reviewed by the Board throughout the year via:

- Reliance upon the Audit Committee for assurances that the system of internal control is sound
- Assurances from the Quality and Clinical Risk Committee on issues relating to clinical governance, risk management and divisional clinical leadership
- The structure, nature and content of Board meetings during 2017/18 which enabled the Board to provide adequate challenge on and gain suitable assurance in relation to issues relating to performance, quality and safety within the Trust
- The effective engagement of internal audit and an internal audit plan directed at areas where the control environment can be further strengthened (including clinical audit)
- A prioritized clinical audit programme covering national statutory and mandatory audits, priority audits and local interest audits. Further detail of the 2017/18 programme is set out in the Quality Report at pages 121 to 127
- Engaging independent assurance throughout the year through peer review and regulatory review.

Continued improvement and development work in the control environment will be undertaken in 2018/19.

Board of Directors

The governance framework of the Trust is defined in the information on the Trust Board and its sub-committees and the Council of Governors in Section 2 of the Annual Report. It explains the scope of each committee and the issues reported to it. The attendance of non-executive directors and executive directors at Board and committee meetings is detailed on page 45 of the Report.

Monitor's Code of Governance

In July 2014, Monitor published the NHS Foundation Trust Code of Governance (replacing the 2010 version). The purpose of the Code of Conduct is to assist NHS Foundation Trust boards in improving their governance practices by bringing together best practice from the public and private sector corporate governance. The Code is issued as best practice advice, but imposes some disclosure requirements which all foundation trusts are required to follow.

Milton Keynes University Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The table below explains the three points where the Trust does not comply with the code of governance, together with an explanation of why it does not.

Provision	Explanation for non-compliance
A.5.6 The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns.	The Council of Governors raise concerns at their regular meetings which members of the Board of Directors attend. In addition, the lead governor meets with the chairman and can raise issues on behalf of the Council. The senior independent director also meets informally with governors to discuss issues and governors can raise concerns through these meetings.
B2.4 The chairman or an independent non-executive director should chair the nominations committee.	The Council of Governors believe that the Non-Executive Director appointment committee (formally the Nominations Committee) should be chaired by a member of the Council of Governors, as the Council of Governors has a responsibility for the appointment of Non-Executive Directors. This has been in effect since 2008/9 and is reflected in the Trust's Constitution.
B2.9 An independent external adviser should not be a member of or vote on the nominations committee(s)	The Nominations Committee has always valued the input of the independent external adviser, particularly as the Trust has usually selected a serving Chair or non-executive director of another trust to act in this capacity.

The Audit Committee

The Audit Committee provides assurance to the Board on:

- The effectiveness of the organisation's governance, risk management and internal control systems;
- The integrity of the Trust's financial statements, the Trust's Annual Report and in particular the statement on internal control;
- The work of internal and external audit and any actions arising from their work.

The Audit Committee has oversight of the internal and external audit functions and makes recommendations to the Board and to the Nominations Committee of the Council of Governors where appropriate on their reappointment.

The Audit Committee reviews the findings of other assurance functions such as external regulators and scrutiny bodies and other committees of the Board.

The executive directors have provided all the information contained in the Annual Report and accounts. The non-executive directors have had an opportunity to comment on the draft document and the audit committee reviews the report and considers it fair, balanced and understandable.

The Finance and Investment Committee

The Finance and Investment Committee focuses on financial and investment issues and takes an overview of operational activity and performance against national and local targets.

Internal Audit

The Audit Committee agrees an annual risk based internal audit plan and receives reports on the outcomes of the reviews of the system of internal control during the course of the financial year.

KPMG are the providers for internal audit and for 2017/18 the Head of Internal Audit opinion was significant assurance with improvement opportunities on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control.

In 2017/18 KPMG completed 5 internal audit reports:

- 3 reports with an assessment of "significant assurance with minor improvement opportunities";
- 2 reports with an assessment of partial assurance with improvements required
- 0 report with dual ratings of significant assurance on design effectiveness, and partial assurance on operational effectiveness.

It should be noted that the latter three reviews listed below were specifically commissioned by the Trust in the knowledge that these are areas where there have been challenges.

The areas the reports covered are as follows:

Financial Management and core financial processes	Significant assurance with minor improvement opportunities
BAF and risk management	Significant assurance with minor improvement opportunities
Clinical Audit	Partial assurance with improvements required
Capital Project Governance	Partial assurance with improvements required
Agency staffing (locum staff)	Significant assurance with minor improvement opportunities

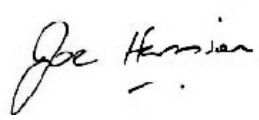
External Audit

Deloitte LLP, the external auditor provides assurance to the Trust on an ongoing basis by attending all Audit Committee meetings and by undertaking the annual audit of the accounts and Annual Report and a limited assurance review of the Quality Account. For 2017/18, the external auditor has concluded that:

- The financial statements give a true and fair view of the state of the Trust's affairs, and have been properly prepared in accordance with the accounting policies directed by NHS Improvement, and in accordance with the National Health Services Act 2006;
- His opinion in respect of the use of resources is to be qualified on the basis that the steps taken by management during 2017/18 to improve governance over the quality of its data have not had a full year effect, and that the Trust incurred a deficit of £16.1m to the year ended 31 March 2018, and has a planned deficit of £7.9m for 2018/19;
- His limited assurance opinion in respect of his review of the Quality Report 2017/18 is to be qualified in relation to the A&E 4 hour wait and 18 week RTT - incomplete indicators.

Conclusion

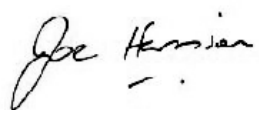
Based on my review, I am aware of on-going internal control issues regarding financial sustainability and data quality. The Trust is committed to the continuous improvement of its processes for internal control and assurance, and this has already led to the lifting by NHS Improvement of historical conditions that had been placed on the Trust's licence. Although the Trust remains in deficit, it has met and exceeded its control total, and robust governance arrangements are now in place to assure data quality across the organisation. I am confident that these will lead to marked and sustainable improvements in 2018/19.



Joe Harrison
CHIEF EXECUTIVE

Date: 25 May 2018

Accountable Officer's signature



Joe Harrison
CHIEF EXECUTIVE

Date: 25 May 2018

Section 3

Quality Report

Quality Report

Part 1: The Quality Account

1.1 Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In addition, the Trust was required to select 3 indicators in respect of which its performance is to be subjected to testing by the external auditors. Two of these indicators - the targets to treat 95% of patients attending the Emergency Department within 4 hours, and for 92% of patients on incomplete pathways to be referred to treatment within 18 weeks – are mandated by NHS Improvement. The other indicator, which was selected by the Council of Governors, was around the target to report CT, MRI and plain film GP/outpatient examinations within 11 working days. The outcome of the auditors' testing of the mandated indictors is set out at Annex 3 to this Quality Report.

1.2 Statement on quality from the Chief Executive

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

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

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

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

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

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

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

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

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

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

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

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

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

We are committed to continuing to improve the quality of the care we provide. Each year we challenge ourselves to do better so that our patients get the best possible care, treatment and experience whilst in our care or using our services. We are aware that in 2017/18 we received around 50% more complaints about our services than we did in the previous year. We welcome the feedback and the opportunity to do better for our patients. We are working hard to improve the experience that our patients receive when they use our services and this will continue to be our priority in 2018/19.

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

1.3 Statement of Assurance

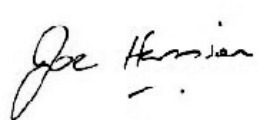
There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

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

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

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

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, with the exception of ongoing data quality issues identified in the Annual Governance Statement.



Joe Harrison
CHIEF EXECUTIVE

Date: 25 May 2018

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

2.1 Priorities for Improvement in 2018/19

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

The second and third priorities relate to issues in relation to which the Trust has received feedback from patients both formally through complaints and staff surveys, and informally, that improvements are required. The WHO checklist on the other hand is a key component of the Trust's efforts to maintain the safety of patients undergoing surgery – the Trust's approach to managing the checklist was revised following one the Never Events referred to later in this report, and it was considered prudent to take the opportunity to assess the overall efficacy of the process.

Priorities for 2018/19:

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

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

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

2.1.1.2 Why have we selected this as a priority?
The central tenet of medicine is 'first, do no harm'. Many of the interventions which we undertake in modern healthcare are complex and therefore prone to error. Two fundamental steps in maximising the safety of complex processes in medicine are standardisation and communication.

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

2.1.1.3 What is our past performance in this area?
The WHO surgical safety checklist is completed in a very high proportion of relevant cases (>98%). However, the completion of the checklist does not in itself tell us about the safety culture within theatres and the degree to which standardisation and communication are optimised.

2.1.1.4 How will we monitor and measure our performance in 2018/19?
- We will revise and agree the methodology for quantitative reporting in relation to the use of the WHO surgical safety checklist.
- We will work with the regional Patient Safety Collaborative and others to design a mechanism through which we can obtain regular objective feedback about the conduct of the checklist and our overall safety culture
- We will establish a working party, a sub-group of the Theatres Improvement Group, to look at measures to optimise patient safety in the theatre environment
- We will adopt 'Greatix', a technique known as appreciative enquiry, in order to ensure that we learn from best practice within the organisation
- We will invest in our theatres environment to improve 'safety by design'
- We will work with colleagues outside the surgical environment to ensure that other procedures also adopt best practice in relation to checklists and communication

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

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

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

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

The Gold Standard Framework is a programme that has been established for over 15 years. The programme involves staff in the community, nursing homes and in hospital settings, with the aim of improving the care of patients who are in their last year of life. The programme includes teaching and on-going support; and empowers staff to identify people in the last year of life and more advanced care planning discussions. This enables better care through proactive management and empowers patients as equal partners in planning their care and treatment.

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

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

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

2.1.2.3 What is our past performance in this area?
There were 30 complaints about end of life care at the hospital between January 2017 and January 2018. Common themes include poor communication and a lack of compassion and dignity.

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

2.1.2.4 How will we monitor and measure our performance in 2018/19?
There are a number of auditable and measurable key performance indicators that will help to assess the impact of Gold Standard Framework training including:

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

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

2.1.3 Priority 3:
Improving Outpatients (Clinical Effectiveness)

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

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

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

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

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

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

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

2.2 Our Performance against Priorities for Improvement in 2017/18

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

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

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

2.2.1 Priority 1:

Improving the management of patients with sepsis

2.2.1.1 Description of the priority

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

2.2.1.2 Why did we select this priority?

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

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

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

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

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

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

2.2.2 Priority 2:

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

2.2.2.1 Description of the priority

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

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

2.2.2.2 Why did we select this priority?

Although the stillbirth and neonatal mortality rate has fallen by a fifth in England in the last decade, the NHS has recently set out a national ambition to halve the rates of stillbirths by 2025. The Saving Babies' Lives Care Bundle is designed to reduce stillbirth and early neonatal death.

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

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

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

For high-risk births we regularly check the baby's heart rate using an electronic trace called a CTG (Cardiotocography) which gives an indication of fetal wellbeing.

Reading the trace is a complex process so we undertake a second check of every trace to reduce the risk of incorrect interpretation. This is undertaken by the midwife caring for the woman and a second midwife who acts as an independent review. This process is known as 'fresh eyes'.

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

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

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

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

2.2.3.2 Why did we select this priority?
The staff engagement element of the annual NHS staff survey is derived from elements of engagement across a number of consistent questions, including on the levels of motivation and satisfaction staff feel; and their involvement and willingness to be an advocate of the hospital and its services. The scores across all elements are converted into an overall staff engagement score for the hospital, which can be benchmarked or compared with other NHS organisations. Having a highly motivated and engaged workforce is vital to staff wellbeing and critical in delivering high quality patient care.

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

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

In the 2017 staff survey, the hospital's overall staff engagement score of 3.80 out of 5 (the higher the better) has remained unchanged since 2015 and is average in comparison to Trusts of a similar type. However, the percentage of staff who consider that the Trust takes positive action on their health and wellbeing increased from 27.58% in the 2015 staff survey to 41.55% in 2017.

In relation to the key finding of 'staff recommendation of the Trust as a place to work or receive treatment', the Trust's score remained average at 3.74, as it was in 2016; marginally below the national average of 3.75.

The key finding for 'staff motivation at work' decreased slightly from 3.95 in 2016 to 3.93 in 2017 but the Trust is above the national average of 3.92.

With regard to 'staff ability to contribute towards improvements at work', the Trust's score remained at 70% in 2017, as it was in 2016 and was in line with the national average of 70%.

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

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

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

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

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

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

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

The SAFER patient flow bundle stands for:

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

Into 2018/19 the challenge will be continuing the initiatives and sustaining positive change. Sustainability is achieved 'when new ways of working and improved outcomes become the norm' (NHS Improving Quality). The control predominantly resides among the professionals delivering services so we as an organisation need to find ways to support, encourage and facilitate clinicians to ensure these initiatives last long term.


Thank u

2.3 Statement of Assurance from the Board of Directors

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

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

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

2.3.1 Clinical Coding Audit

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

2.3.2 Submission of records to the Secondary Users Service

Milton Keynes University Hospital NHS Foundation Trust submitted records during 2017/18 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. Details of this submission can be found at page 133.

2.3.3 Information Governance Assessment Report

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

2.4 Participation in clinical audits

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

During 2017/18, The Trust participated in 90% (37 out of 41) of eligible national audits, and 100% (3 out of 3) of national confidential enquiries in which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Milton Keynes University Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below.

No.	Name of Audit	Did MKUH participate?	Reason for non-participation	Stage	Number of cases submitted (by % of total number)
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes		Action planning	100%
2	Adult Cardiac Surgery	N/A	Not applicable	Not applicable	Not applicable
3	BAUS Urology Audits: Cystectomy	N/A	Not applicable	Not applicable	Not applicable
4	BAUS Urology Audits: Female stress urinary incontinence	Yes		Data collection	Not available
5	BAUS Urology Audits: Nephrectomy	Yes		Action planning	100%
6	BAUS Urology Audits: Percutaneous nephrolithotomy	Yes		Data collection	Continuous data collection
7	BAUS Urology Audits: Radical prostatectomy	N/A	Not applicable	Not applicable	Not applicable
8	BAUS Urology Audits: Urethroplasty	N/A	Not applicable	Not applicable	Not applicable
9	Bowel Cancer (NBOCAP)	Yes		Awaiting report	Continuous data collection
10	Cardiac Rhythm Management (CRM)	Yes		Action plan monitoring	100%
11	Case Mix programme (CMP)	Yes		Action plan monitoring	100%
12	Congenital Heart Disease (CHD)	N/A	Not applicable	Not applicable	Not applicable
13	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	N/A	Not applicable	Not applicable	Not applicable
14	Diabetes (Paediatric) (NPDA)	Yes		Awaiting report	Continuous data collection
15	Elective Surgery (National PROMs Programme)	Yes		No actions required	Continuous data collection
16	Endocrine and Thyroid National Audit	Yes		No actions required	Continuous data collection
17	Falls and Fragility Fractures Audit programme (FFFAP)	Yes		Action monitoring	100%
18	Fractured Neck of Femur	Yes		Action planning	100%
19	Head and Neck Cancer Audit (HANA) (TBC)	Yes		Action planning	100%
20	Inflammatory Bowel Disease (IBD) programme	Yes		Action planning	100%
21	Learning Disability Mortality Review Programme (LeDeR)	Yes		Awaiting report	Continuous data collection
22	Major Trauma Audit	Yes		Action planning	100%
23	Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes			Not available
24	National Audit of Anxiety and Depression	No	Not applicable		Not applicable
25	National Audit of Breast Cancer in Older Patients (NABCOP)	Yes		Action national report	Not available
26	National Audit of Dementia	Yes		Action plan monitoring	Not available
27	National Audit of Intermediate Care (NAIC)	No	Not applicable	Not applicable	Not applicable
28	National Audit of Psychosis	No	Not applicable	Not applicable	Not applicable

No.	Name of Audit	Did MKUH participate?	Reason for non-participation	Stage	Number of cases submitted (by % of total number)
29	National Audit of Rheumatoid and Early Inflammatory Arthritis	No	Department restructure	Not applicable	Not participated
30	National Audit of Seizures and Epilepsies in Children and Young People	Yes		Data collection commencing	Continuous data collection
31	National Bariatric Surgery Registry (NBSR)	N/A	Not applicable	Not applicable	Not applicable
32	National Cardiac Arrest Audit (NCAA)	No	Trust has run local audit	Data collection commenced 2018	Trust enrolled in national audit Jan 2018
33	National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Yes		Action plan monitoring	100%
34	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	N/A	Not applicable	Not applicable	Not applicable
35	National Comparative Audit of Blood Transfusion programme	Yes		Action planning	Not available
36	National Diabetes Audit – Adults	Yes		Awaiting report	Not available
37	National Emergency Laparotomy Audit (NELA)	Yes		Action planning	100%
38	National Heart Failure Audit	Yes		Action plan monitoring	100%
39	National Joint Registry (NJR)	Yes		Action plan monitoring	100%
40	National Lung Cancer Audit (NLCA)	Yes		Action plan monitoring	100%
41	National Maternity and Perinatal Audit	Yes		Action plan monitoring	100%
42	National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes		Action plan monitoring	100%
42	National Ophthalmology Audit	No	IT interface issues	Not applicable	Not applicable
43	National Vascular Registry	N/A	Not applicable	Not applicable	Not applicable
44	Neurosurgical National Audit Programme	N/A	Not applicable	Not applicable	Not applicable
45	Oesophago-gastric Cancer (NAOGC)	Yes		Action planning	100%
46	Paediatric Intensive Care (PICANet)	Yes		Action plan monitoring	100%
47	Pain in Children	Yes		Action planning	100%
48	Prescribing Observatory for Mental Health (POMH-UK)	N/A	Not applicable	Not applicable	Not applicable
49	Procedural Sedation in Adults (care in emergency departments)	Yes		Action planning	100%
50	Prostate Cancer	Yes		Action plan monitoring	100%
51	Sentinel Stroke National Audit programme (SSNAP)	Yes		Action plan monitoring	100%
52	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes		Action plan monitoring	Not available
53	UK Parkinson's Audit	Yes		Action plan monitoring	100%

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

National Confidential Enquiry into Patient Outcome and Death Study Eligible 2016-17	Participated	Cases Submitted
Cancer in Children, Teens and Young Adults	Yes	4
Chronic Neuro disability	Yes	4
Young People's mental health	Yes	1
Number of cases submitted were the number requested by NCEPOD		


MKUH
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CYBERNET

National audit reports

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

National Chronic Obstructive Pulmonary Disease Audit – Inpatient work stream

RECOMMENDATION(S)/OUTCOMES DISCUSSION POINTS AND ACTIONS POINTS WE INTEND TO TAKE
1. The clinical lead for Respiratory and COPD is working collaboratively with the CCG to integrate services for patients discharged with COPD and other airways diseases, providing support for community based diagnosis, non- pharmacological care, optimum pharmacological management and overall leadership.
2. Strengthening IT provision across primary and secondary care to enable seamless access to data at both sites thus improving patient care.
3. Reviewing and augmenting current smoking cessation services across both locations.
4. Considering opportunities to make Spirometry available on ICE for easy access to all.
5. Augmenting staffing levels in Non Invasive Ventilation bays on both male and female respiratory ward improving quality of care.
6. Prioritising complex COPD patients staying beyond 48 hours to the Respiratory Wards.
7. Expanding the respiratory specialist nursing service to provide specialist 24/7 in-reach to admitted COPD and other airway disease patients across respiratory and non-respiratory, and especially on the acute medical footprint.
8. Working towards the development of a COPD MDT to work across primary and secondary care, discussing complex and challenging COPD and other Airways disease cases, focusing on patients' individual needs.

National Bowel Cancer Audit

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

National Paediatric Diabetes audit

RECOMMENDATION(S)/OUTCOMES DISCUSSION POINTS AND ACTIONS POINTS WE INTEND TO TAKE
1. Continue to focus resources on patients with high HbA1c – nurse led high HbA1c clinics.
2. Employ a psychologist as part of the diabetes team to support children and families with diabetes – business case accepted and discussion with Children and Adolescent Mental Health Services (CAMHS) underway to employ additional team member.
3. Work with IT to improve design and function of SPARKLE database so that activity and data is captured in national audit.
4. Continue to offer pump therapy to families.

National Diabetes in Pregnancy audit

RECOMMENDATION(S)/OUTCOMES DISCUSSION POINTS AND ACTIONS POINTS WE INTEND TO TAKE
1. Improve preconception care in primary care for women with type 2 – this would improve the number of women taking folic acid preconception, HbA1c levels in first trimester and early referral to the diabetes team

National Prostate Cancer

RECOMMENDATION(S)/OUTCOMES DISCUSSION POINTS AND ACTIONS POINTS WE INTEND TO TAKE
1. New biopsy methods using template based approaches have been introduced but trans rectal ultrasound (TRUS) biopsy still remains the most commonly utilised nationwide (85% of men).
2. The Trust should start planning for the performance of template biopsies as this will increase theatre resource usage considerably.

National neonatal audit programmer

RECOMMENDATION(S)/OUTCOMES DISCUSSION POINTS AND ACTIONS POINTS WE INTEND TO TAKE
1. Improve admission temperature by revising guidelines on usage of plastic bags for <34 weeks and education on resuscitation
2. Improve administration of breast milk within 24 hours of admission by allocating dedicated staff and resources- recruitment is in progress
3. Increase the number of babies on breast milk on discharge.

Local audits

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

Urology Department Quality Improvement activity following participation in national and local audits

1. Set up new urology stone MDT
2. Set up internal urology M&M
3. Review post-op readmissions with sepsis
4. Hold urology away day

30 days mortality and 8 days re-admission

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

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

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

Assessment of vitamin D deficiency in ward 3 inpatients

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

Audit of compliance with the standards for melanoma reporting

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

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

1. Use once daily Gentamicin instead of multiple dosing
2. Delay initiating Rifampicin where indicated
3. Prolong incubation of blood cultures for suspected endocarditis

Audit of Intra-Abdominal sepsis Management

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

Audit of Orthognathic Surgery Waiting Times

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

Audit of Percutaneous Breast Biopsies

1. Audit shows 98% accuracy in current practice.

Audit of sepsis management in Gynaecology patients

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

British Thoracic Society National Paediatric Asthma Audit

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

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

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

Collection of blood products using BloodTrackSystem

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

Compliance to the BAUS Enhanced recovery Programme

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

Dietetic Record Card Re-audit

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

Febrile neutropenia in children with malignancy

1. Review oncology patients admission pathway
2. Febrile Neutropenia departmental teaching to be held.
3. Paediatric oncology service -trainee induction day to be held, and training to be provided for staff particularly nursing staff on ward 4 on Central line access

Incisional hernia repair audit

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

Induction of labour (QS60)

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

Initial clerking of patients presenting with abdominal pain

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

Major Obstetric Haemorrhage

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

Milton Keynes Bowel Cancer Audit report

Outcomes of this audit pending data quality review.

MUST Audit using BAPEN's nutritional care tool

1. Aim to MUST screen all patients within 6 hours of admission
2. Fill in MUST tool correctly – training is provided in Essential Skills sessions for nursing staff and HCAs as well as ad hoc training sessions on the wards
3. Take the correct actions based on the MUST score – training as in point 2 above, feedback in person to nurses/HCAs on the ward
4. Offer patients extra food/drink where needed as well as assistance

PICC line service by imaging

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

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

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

Postnatal Care Pathway

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

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

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

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

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

Quality Improvement Project (QIP) on IV Cannula

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

Review of the women's health inpatients service

1. There should be an uplift in staffing for the Women's and Men's health team to the extent of one Band 5, within the next 6 months. This is to ensure that the ward can be covered with an appropriate time allowance daily, including those periods of staff leave, training and sickness.
2. It is also proposed that all women who have an episiotomy without assisted delivery and also those with a second degree tear should be offered information from a physiotherapist with regard to wound healing, pelvic floor exercises, bladder care and return to exercise.

Sepsis in Maternity - follow up audit

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

Treatment of patients refusing blood

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

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

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

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

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

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

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

2.5 Participation in Clinical Research

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

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

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

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

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

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

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

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

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

The ‘Canine olfactory detection of urological cancer from human urine’ (MDD) study has continued to receive media attention and the team have delivered some successful healthy volunteer recruitment events in and around Milton Keynes as well as continuing to recruit eligible patients attending MKUHFT.

The team have submitted expressions of interest for several commercial studies during this financial year. We have been awarded commercial studies in cancer, emergency medicine, cardiology, diabetes and stroke. This demonstrates that MKUH is becoming an organisation recognised by industry, forging relationships with commercial partners wanting to perform quality research within our organisation.

This will continue to drive an increase in the quality and quantity of research opportunities offered to our patients and public.

2.6 Goals agreed with Commissioners (CQUIN)

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

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

2.6.1 National Goals

2017/18 CQUINS FOR MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST			
	Indicator Name	**High level detail**	**Expected delivery 2017/18**
1a	Improvement of health and wellbeing of NHS staff	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, Musculo-skeletal (MSK) and stress	The Trust achieved 50% of this CQUIN
1b	Healthy food for NHS staff, visitors and patients	Building on changes made relating to 2016/17 CQUIN including implementation of healthy food initiatives, including; the banning of price promotions and advertisements on sugary drinks and food high in fat, sugar and salt, ensuring 70% of drinks stocked are sugar free, 60% of confectionery does not exceed 250 kcal and 60% pre-packed meals contain 400 kcal or less	This CQUIN has been achieved in full.
1c	Improving the uptake of flu vaccinations for front line staff within Providers	Achieving an uptake of flu vaccinations by frontline clinical staff of 70%.	This CQUIN has been achieved in full. The Trust achieved a total frontline flu vaccination uptake of 78.07%.
2a	Timely identification for sepsis in emergency departments and acute inpatient settings	Demonstrating percentage of patients who met the criteria for sepsis screening and were screened for sepsis. This indicator applied to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards	The Trust achieved 25% of this CQUIN
2b	Timely treatment of sepsis in emergency departments and acute inpatient settings	Demonstrating the percentage of patients who were found to have sepsis in sample 2s and received IV antibiotics within 1 hour.	The Trust achieved 70% of this CQUIN.
2c	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours	Demonstrating the percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hour with documented outcome of review recorded	This CQUIN has been achieved in full.
2d	Reduction in antibiotic consumption per 1,000 admissions	There are three parts to this indicator: 1. Total antibiotic usage per 1,000 admissions 2. Total usage of carbapenem per 1,000 admissions 3. Total usage of piperacillin-tazobactam per 1,000 admissions	The Trust achieved 66% of this CQUIN.
4	Improving services for people with mental health needs who present to ED	Reduce by 20% the number of attendances to ED for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions and establish improved services to ensure this reduction is sustainable	This CQUIN has been achieved in full.
6.	Offering Advice and Guidance (A&G)	To set up and operate advice and guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care.	The Trust achieved 50% of this CQUIN
7.	NHS e-Referrals	Ensuring 100 per cent of consultant led 1st outpatient services are available on the NHS e-Referral Service (e-RS) with adequate slot polling taking place to allow patients to book appointments evidenced by a reduction in 'Appointment Slot Issues' to a rate of 4% or less	The Trust did not achieve this CQUIN.
8.	Supporting Proactive and Safe Discharge	Increasing the proportion of patients admitted via non-elective route discharged to their usual place of residence within 7 days of admission by 2.5 per cent. Timely submissions of Emergency Care Data Set	The Trust achieved 55% of this CQUIN

2.6.2 Specialised Goals

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

For 2016/17, the Trust achieved £2.79m out of a potential total of £4.1m.

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

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

2.7.2 Overall Ratings for Milton Keynes University Hospital

Specialty Area	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Outstanding	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and Gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of Life Care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and Diagnostic Imaging	Good	Not Rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

2.7.3 Key findings from the report

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

2.7.4 Areas of Outstanding Practice

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

2.7.5 Areas of Compliance or enforcements

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

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

- The Emergency Department did not comply with guidance relating to both paediatric and adult mental health facilities.
  The Trust has built a dedicated mental health assessment room and now has a purpose built paediatric emergency department with a separate entrance.

- Staff patients and visitors did not appear to observe the hand-washing protocols in the emergency department.
  The ED has introduced more regular audit of the hand-washing protocols in the department.

- The non-invasive ventilation policy was out of date.
  Policy now in date.

- The Medical Care Service did not have a policy for dealing worth outlying patients.
  Policy now in place.

- In the Maternity Service examples were shared of inappropriate behaviours and lack of teamwork at consultant level in the service. These behaviours were not observed during the inspection.
  Invested in multi-disciplinary leadership and human factors training which includes all of the consultant body. In addition timetables have been rescheduled to allow for team meetings and more multi-disciplinary ward rounds.

- Not all medical staff in maternity has completed the required level of safeguarding children's training.
  Compliance now remains over 90%.

- There was poor compliance with assessing the risk of venous thromboembolism in the maternity service.
  This continues to be a challenge however our new electronic tool for data collection goes live in May 2018.

2.8 Data Quality

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

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

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

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

4) Establishment of an organisational wide training programme to ensure that all staff members are fully conversant with national and local polices. In addition, this training programme ensures the Trust actively provides context to the importance of accurate data collection and the subsequent use of relevant key data items, thereby promoting understanding across all staff groups.

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

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

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

As part of their work, the Trust's external auditors are required to perform sample testing of three performance indicators. For 2017/18, this testing was carried out in relation to two mandated indicators - 18 week referral to treatment – incomplete pathways, and A&E 4 hour waiting times – as well as a local indicator chosen by the Council of Governors – radiology reporting times. The auditors have identified data quality issues in respect of the 18 week RTT and A&E 4 hour indicators. The steps that the Trust is taking to improve data quality, as described above, will address many of these issues, but in addition, specific training is to be provided to A&E and outpatient staff to ensure more accurate recording and the avoidance of errors, and in relation to RTT, that there is to be more divisional management involvement in the validation processes.

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

Data item	Admitted	Outpatients	A&E
Completeness NHS number	99.2 (99.4)	99.7 (99.5)	98.1 (97.1)
Completeness ethnicity	99.4 (96.2)	99.1 (94.2)	94.9 (94.9)
General Medical Practice Code	100	100	100

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

2.9 Learning from Deaths

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

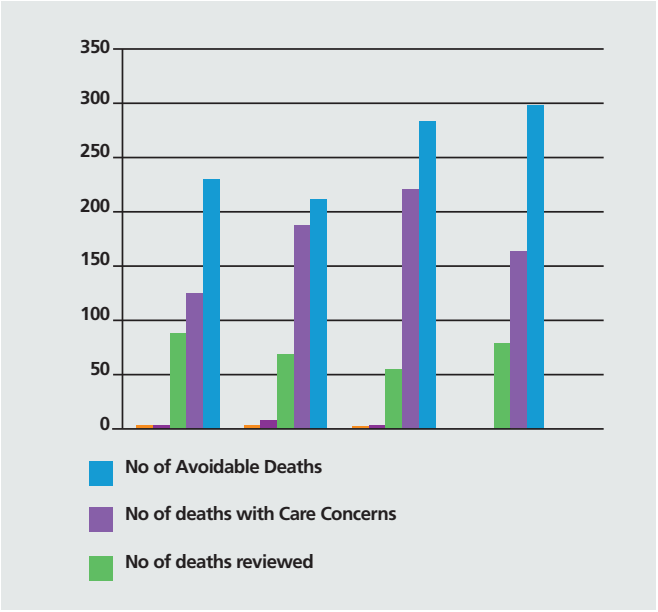
1. Been reviewed and assessed by the consultant responsible for the patient's care with the potential for the case to be 'screened out' of further formal review. This active assessment process recognises that in many cases death in hospital will have been inevitable and appropriate. The process assists in directing collective review efforts to those cases where multi-professional review is likely to lead to learning. A subset of those cases 'screened out' is subjected to formal review at random.
2. Undergone formal review – the Trust aims for ~ 25% of all deaths to undergo a formal review process. It should be recognised that deaths that occur within Q4 are still undergoing the process of formal review in accordance with the Trust's mortality policy.
3. Judged as potentially 'avoidable' – using the current system of classification within the Trust this includes 'suboptimal care where different management MIGHT have changed outcome and 'suboptimal care where different management WOULD have changed outcome'
4. Judged as 'non-avoidable' but where there have been care quality concerns identified. This includes 'suboptimal care where different management WOULD NOT have changed outcome'.

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

Data item	Q1	Q2	Q3	Q4
No. of deaths	230	211	284	298
No. of deaths reviewed by responsible consultant (% of total)	125 (54%)	187 (89%)	220 (77%)	163 (55%)*
No. of investigations (% of total) ǂ	88 (38.2%)	63 (29.9%)	54 (19%)	79 (26.5%)*
No. of deaths with Care Quality concerns (%)	3 (1.3%)	7 (3.3%)	3 (1.1%)	0*
No. of potentially avoidable deaths (%)	2 (0.8%)	2 (0.5%)	1 (0.5%)	0*

ǂ All deaths that have been investigated have been through the initial case record review process

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



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

Q1 Avoidable deaths (2)

1. A woman in her 8th decade died in the Department of Critical Care. Following a Serious Incident investigation it was concluded that there were delays in chasing the results of investigations which may have contributed to the death of the patient. Knowledge of the results in an appropriate timeframe may have allowed surgical treatment to remove the source of sepsis.

Actions and assessment of impact (in italics)

   a. Changes to Standard Operating Procedures to clarify members' roles – *problems that arise in chasing of investigations associated with Serious Incidents are reviewed in the Trust Serious Incident Review Group (SIRG).*

   b. Additional afternoon clinical handover for on call staff – *in place.*

2. A woman in her 8th decade died of a potentially treatable surgical problem. A Serious Incident review identified failures in escalation of care in a patient with deteriorating vital signs and blood results as per Trust policy, uncompleted Trust Sepsis documentation and insufficient senior clinical review. It was considered that these elements of suboptimal care may have contributed significantly to the woman's death.

Actions and assessment of impact (in italics)

   a. Education to embed Sepsis 6 guidance within surgical team – *newly appointed Trust Sepsis Nurse whose role includes education and reviewing adherence to Sepsis 6 guidance.*

   b. Surgical team to develop working practice in line with National 7 Day Standards (7DS) guidance including consultant review of emergency patients – *Trust currently reviewing adherence to 7DS guidance and engaging in national 7DS audits.*

   c. Additional training for nursing staff completing NEWS observations charts – *ongoing action.*

   d. Teams to adopt SBAR communication tool to support escalation of deteriorating patients - *problems that arise in use of SBAR tools associated with Serious Incidents are reviewed in SIRG.*

Q2 Avoidable deaths (1)

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

Actions from SIRG and assessment of impact (in italics);

   a. Instil culture of screening for sepsis – *ongoing review by Sepsis working group.*
   b. Strengthen online medical handover tool – *to review following eCARE implementation.*
   c. Friday afternoon handover to on–call team re-instigated – *in place.*
   d. Update Standard Operating Procedure for duties of On-Call doctor to clarify team roles.

Q3 Avoidable deaths (1)

1. A surgical patient in his 10th decade had relatively minor emergency surgery. Intravenous fluids were prescribed at a rate too great for a frail elderly patient with chronic heart failure. This likely contributed to a degree of fluid overload and pulmonary oedema. Areas of improvement were identified in the initial clerking of the patient on admission to hospital and poor documentation of the patient's medicines.

Actions and assessment of impact (in italics)

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

2.9.2 Indicators 27.7 27.8 and 27.9

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

2.9.4 Palliative Care (Core indicators 13)

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

2.10 Reporting against core indicators

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

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

a) The national average for the same; and

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

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

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

	Level	2013/14	2014/15	2015/16	2016/17	2017/18
DOMAIN 1 PREVENTING PEOPLE FROM DYING PREMATURELY						
Summary Hospital-Level Mortality Indicator (SHMI)	MKUHFT	1.04 Band 2	0.94 Band 2	1.04 Band 2	1.04 Band 2	**0.99 Band 2**
	National	1.00	1.00	1.00	1.00	**1.00**
	Other Trusts High /Low	It is not appropriate to rank trusts by SHMI				

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

There is an increasing level of scrutiny of mortality information across services provided by the Trust an in depth analysis where mortality levels are outside the normal range. We are also now reviewing a percentage of all deaths that occur within the hospital, as described on page 134 of this report.

The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period was 5.49%.

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

	Level	2013/14	2014/15	2015/16	2016/17	2017/18
DOMAIN 3: HELPING PEOPLE TO RECOVER FROM EPISODES OF ILL HEALTH OR FOLLOWING INJURY						
Groin hernia surgery	MKUHFT		82.3%	88.8%	Insufficient data	**81.76%**
	National		87.7%	87.8%	88.0%	**80%**
Varicose veins surgery	MKUHFT		Insufficient data	Insufficient data	Insufficient data	**Insufficient data**
	National		84.1%	83.7%	84.2%	**77.6%**
Hip replacement surgery	MKUHFT		78.0%	83.1%	Insufficient data	**75.8%**
	National		79.7%	80.0%	81.1%	**77.8%**
Knee replacement surgery	MKUHFT		81.0%	74.6%	75.5%	**74.5%**
	National		0.7%	74.3%	Insufficient data	**74.6%**

The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This helps the service to improve the quality of its care.

Milton Keynes University Hospital NHS Foundation Trust has taken the following actions to improve its score: taking steps to improve the response rate of post-operative questionnaires, and reviewing the data when it becomes available. The latest data for 2017/18 was released in February 2018 and relates to the period from April 2016 to March 2017. This data shows that a total of 509 questionnaires were returned. This compares to 644 questionnaires returned in 2016/17, but it should be noted that the sending out of questionnaires was discontinued in October and November 2017 in relation to varicose vein and groin hernia respectively as this was no longer mandated.

2.10.3 Indicator 8: Emergency Readmissions to hospital within 28 days

	Level	2013/14*	2014/15*	2015/16*	2016/17**	2017/18**
DOMAIN 3: HELPING PEOPLE TO RECOVER FROM EPISODES OF ILL HEALTH OR FOLLOWING INJURY						
Patients readmitted to a hospital within 28 days of being discharged	MKUHFT	12.20%	11.14%	11.47%	11.14%	**12.2%**
	National	11.61%	12.00%	12.20%	12.33%	**12.5%**
	Other Trusts High /Low	7.87% / 16.95%	7.94% / 15.98%	8.52% / 16.44%	8.45% / 16.19%	**9.4% / 16.4%**

*Data sourced from Dr Foster (full fiscal year)

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

***Please note that this indicator has been temporarily suspended pending a methodology review. This data has once again been sourced from Dr Foster

2.10.4 Indicator 9: Responsiveness to inpatient personal needs

	Level	2013/14	2014/15	2015/16	2016/17	2017/18
DOMAIN 4 ENSURING PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE						
Responsiveness to the personal needs of patients	MKUHFT	65.3%	65.4%		64.6%	**Next update August 2018**
	National	68.7%	68.9%	69.6%	68.1%	
	Other Trusts High /Low	54.4% / 84.2%	59.1% / 86.1%	58.9% / 86.2%	60% / 85.2%	

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission. The Trust's patient experience team continues to work with the clinical teams with a view to improving patients' experience of receiving care. There are a number channels by which patients are able to provide feedback on the care that they have received, and the Trust has responded proactively to these emerging messages. During 2017/18, work started on the drafting of a new patient experience strategy which will be adopted and implemented in 2018/19.

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

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

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

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

	Level	2013/14	2014/15	2015/16	2016/17	2017/18
DOMAIN 5 TREATING AND CARING FOR PEOPLE IN A SAFE ENVIRONMENT AND PROTECTING THEM FROM AVOIDABLE HARM						
Patients admitted to hospital who were risk assessed for venous thromboembolism (Q3 results for each year)	MKUHFT	96.0%	96.0%	95.1%	85.6%	**76.9%**
	National	96.0%	96.1%	95.6%	95.8%	**95.4%**
	Other Trusts High /Low	80% / 100%	90% / 100%	79% / 100%	80% / 100%	**76% / 100%**
Rate of C.difficile infection (per 100,000 bed days)	MKUHFT	22.5%	23.4	10.3	6.1	**Next update August 2018**
	National	14.7%	15.0	14.9	13.2	
	Other Trusts High /Low	0 / 37.1	0 / 62.6	0 / 67.2	0 / 82.7	
Rate of patient safety incidents per 100 admissions (and the rate that resulted in severe harm or death)	MKUHFT	5.1 (0.01)	27.5 (0.06)	28.4 (0.01)	30.7 (0.07)	**Next update May 2018**
	National	8.7 (0.07)	37.1 (0.19)			
	Other Trusts High /Low	1.2 (0) / 15.5 (0.37)	3.6 (0.02) / 82.2 (1.53)			

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

Milton Keynes University Hospital NHS Foundation Trust did not meet this target in 2017/18, in part due to administrative issues associated with the manual collection of some of the data. It is expected that the Trust will report a higher percentage of patients being risk assessed for venous thromboembolism in 2018/19 with the introduction of eCARE.

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

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.

Antimicrobial resistance continues to play an important role in driving the current numbers of Clostridium difficile and the emergence of new types. Clostridium difficile although greatly reduced in terms of the numbers of cases seen at the MKUH, should still be recognised as a major cause of healthcare antibiotic-associated diarrhoea.

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

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

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

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

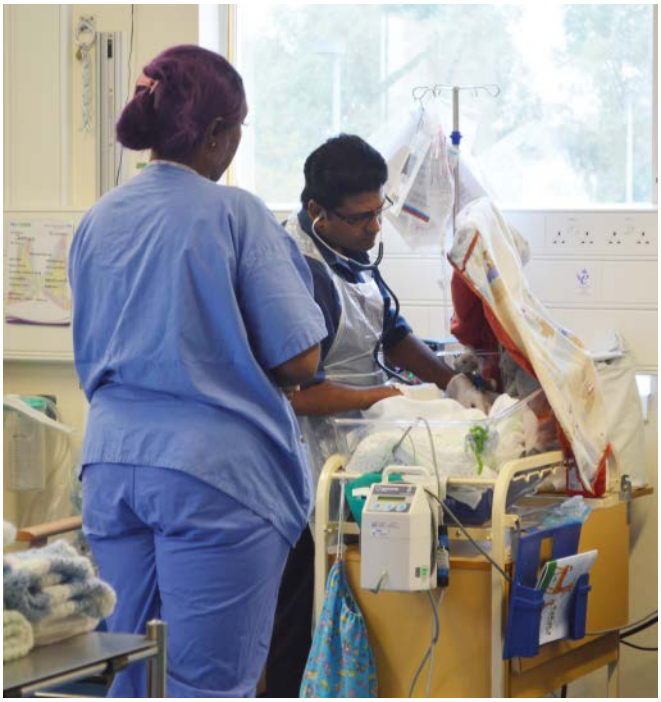
	Level	2013/14	2014/15	2015/16	2016/17	2017/18
DOMAIN 5 TREATING AND CARING FOR PEOPLE IN A SAFE ENVIRONMENT AND PROTECTING THEM FROM AVOIDABLE HARM						
Rate of C.difficile infection (per 100,000 bed days)	MKUHFT	22.5%	23.4	10.3	6.1	**Next update August 2018**
	National	14.7%	15.0	14.9	13.2	
	Other Trusts High /Low	0 / 37.1	0 / 62.6	0 / 67.2	0 / 82.7	

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

The Trust reported 5088 Patient Safety Incidents between 1 April 2017 and 31 March 2018.

Of these, 16 were reported as causing severe harm or death, equating to 0.3% of the total Patient Safety Incidents for the period.

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



Part 3 Other Information

3.1 Review of Quality of Care 2017/2018

3.1.1 Patient Safety

3.1.1.1 Hand Hygiene

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

The Trust's hand hygiene compliance rate for 2017/18 is 86% (77.73% in 2016/17), and the organisation is committed to maintaining and increasing hand hygiene compliance by actively promoting education programmes on hand hygiene and "bare below the elbow". Hand hygiene compliance is audited trust wide on a monthly basis and reported to the infection and prevention and control quarterly meetings.

The Department of Health estimates that roughly 300,000 patients develop a healthcare associated infection (HCAI) in England every year, with 5,000 of those cases proving fatal. HCAIs cost the NHS around £1bn a year and eight out of ten infections are spread through contact with hands.

Like all other acute hospitals, our compliance level fluctuates, despite our employing direct surveillance using the World Health Organisation's (WHO) 'Five Moments for Hand Hygiene` which sets out the most fundamental times for hand hygiene to be undertaken during care delivery and daily routines. It is common for the 'Hawthorne Effect' to manifest itself, where medical, nursing, midwifery and allied health staff become aware they are being watched, which can result in their exhibiting different behaviour from normal. As a result, compliance rates can seem artificially high, and not a true reflection of actual hand hygiene habits.

3.1.1.2 Hospital Acquired Pressure Ulcers (grade 3&4)

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

All pressure ulcers are reported and a pressure ulcer summit is undertaken where all parties involved in the patient's care are invited to review the care with the senior nurse for the area to complete a comprehensive timeline to identify causes, themes and learning. This information is used to inform the decision of category of pressure ulcer and whether it was unavoidable or avoidable and therefore hospital acquired. All grade 3 and 4 pressure ulcers are reported as serious incidents and a 72 hour report is produced using the collation of information from the summits

Grade 3 and 4 pressure ulcers are reported as a potential safeguarding concern regardless of the decision about whether it was avoidable. All such pressure ulcers are monitored monthly through the Trust's Nursing and Midwifery Board and quarterly through the Safeguarding Committee. The prevention of pressure ulcers has been a quality priority for 2017/18 and will continue to be a key indicator of quality and ongoing improvement for 2018/19. In 2017/18, the Trust recorded 16 Grade 3 pressures ulcers, of which 6 were avoidable. There were 2 unavoidable Grade 4 ulcers. By comparison, there were a total of 15 grade 3 and 4 pressure ulcers in 2016/17.

3.1.1.3 Patient Falls

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

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

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

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

3.1.1.4 Duty of Candour

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

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

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

3.1.1.5 Never events

There were four never events during this timeframe.

NHS England Never Event 2

Wrong implant/prosthesis:

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

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

NHS England Never Event 3

Retained foreign object post procedure:

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

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

NHS England Never Event 1

Wrong site surgery:

A patient was admitted electively for a computerised tomography (CT) guided biopsy of the right lung mass. Post biopsy the patient developed a pneumothorax (which is a recognised complication of the procedure). The patient was then repositioned from the prone (lying face downwards) position he had been in for the biopsy to a supine (lying face upwards) position. This led to a chest drain being inserted into the left lung.

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

NHS England Never Event 5

Administration of medication by the wrong route:

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

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

3.1.1.6 Learning

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

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

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

3.1.2 Clinical Effectiveness

Indicator	Measurement used	2013-14	2014-15	2015-16	2016-17	2017-18
CLINICAL EFFECTIVENESS						
Hospital standardised mortality ratio (HSMR)	Risk of death relative to national average case mix adjusted from national data via Dr Foster Intelligence: this is a national definition. Target is below 100	88.1	90.0	82.9	89.5	**89.7**
Perinatal death rate (per 1,000)	This data is provided to the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries)	7.8	4.8	3.9	4.2	**5.8**
Still birth rate	Per 1,000 deliveries	5.7	2.1	3.2	3.4	**4.0**
Readmissions within 30 days	Emergency admissions within 30 days of elective discharge, including day cases. Internally set target	8.1%	7.3%	6.8%	7.2%	**8.2%**

3.1.3 Patient Experience

Indicator	Measurement used	2015-16	2016-17	2017-18
PATIENT EXPERIENCE				
Complaints	The number of complaints from patients received by the Trust. This information is sourced from within the Trust.	902	838	**1256**
Midwife : birth ratio	The number of complaints from patients received by the Trust. This information is sourced from within the Trust.	1 to 32	1 to 31	**1 to 29**
Friends and Family Test (Patient Recommend Rate)	Percentage of patients that said they were likely or very likely to recommend NHS services at the Trust. The data is collected monthly by NHS England on behalf of all trusts		90%	**94%**

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

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

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

3.2 Performance against key national priorities

Indicator	Target and source (internal / regulatory / other)	2014-15	2015-16	2016-17	2017-18
PERFORMANCE AGAINST KEY NATIONAL PRIORITIES AND REGULATORY REQUIREMENTS 2014 TO 2018					
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96% (National)	98%	99%	99%	**100%**
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	85% (National)	87%	84%	86%	**88%**
Maximum wait of 2 weeks from GP referral to date first seen for all cancers	93% (National)	95%	95%	95%	**96%**
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments	98% (National)	100%	100%	100%	**100%**
Maximum waiting time of 31 days for subsequent cancer treatments: surgery	94% (National)	100%	98%	98%	**100%**
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients	93% (National)	96%	95%	94%	**96%**
Referral to treatment in 18 weeks - patients on incomplete pathways	92% (National)	93%	86%	93%	**91%**
Diagnostic wait under 6 weeks	99% (National)	99%	98%	100%	**99%**
A&E treatment within 4 hours (including Urgent Care Service)	95%	92%	94%	92%	**91%**
A&E treatment within 4 hours (Type 1 only)	95%		Not available		**86%**
Plain Film, CT Scan and MRI – Exam to report (GP/ Outpatients) < 11 days**	80%		Not available		**98%**
Cancelled operations: percentage readmitted within 28 days	95% (National)	99%	86%	87%	**67%**
Clostridium difficile infections in the Trust	39 (National)	35	20	10	**13**
MRSA bacteraemia (in Trust)	0 (National)	0	2	2	**3**
MRSA bacteraemia (across Milton Keynes total health economy)	0 (National)	3		5 (includes 1 contaminant)	**3**

**The Trust has an internal target to report 80% of GP/ Outpatient referred MRI, CT and Plain Film scans within 11 working days from the date of examination

Annex 1 – Statement from NHS: Milton Keynes

Thank you for forwarding a copy of the Quality Account for Milton Keynes University Hospital NHS Foundation Trust (MKUHFT) to the Milton Keynes Clinical Commissioning Group (CCG) summarising the achievements against the 2017/18 Trust quality priorities and identifying the 2018/19 priorities. MKUHT has continued to work alongside MKCCG to sustain and improve the quality of the Trust's services throughout 17/18 and the quality account represents a balanced view of achievements, learning and challenges.

The Trust has made an open and honest assessment of performance against the 2017/18 objectives; detailing where the organisation has achieved its quality goals whilst recognising where further improvements could be made. It reflects the Trusts' on-going commitment to quality improvement and addresses key issues in a focused and innovative way.

Improvements in the Saving Babies' Lives Bundle arrangements for reducing stillbirths and early neonatal deaths and a reduction in maternity SIs from 10 to 3 over this 12 month period, demonstrates significant progress for this priority clinical specialty. Continued improvement has been achieved in the reduction of avoidable infections, particularly in C.difficile rates. The CCG is committed to working with the Trust to reduce rates of Gram Negative Blood Stream Infections going forward.

Building on the accomplishments of 2017/18 the CCG anticipates that further improvement will be made through the embedding of early identification and treatment of Sepsis. This has been supported through CQUIN funding since 2014-15 and will continue as a national CQUIN scheme in 2018/19. The Trust should also be commended on the open and detailed account of the work undertaken to safeguard against reoccurrence of Never Events.

The CCG welcomes and supports the three improvement goals for 2018/19 particularly in relation to enhancing patient safety by improving the current use of the WHO patient safety checklist in theatres, enhancing the patient experience at the end of life and improving out- patient services. We are looking forward to seeing the impact of these improvement goals in terms of improving patient safety, enhancing the patient experience and improving patient outcomes.

MKCCG can confirm, to the best of our knowledge, that the Quality Account contains accurate and transparent information in relation to the range and quality of services provided. MKCCG looks forward to working collaboratively with MKUHFT to continually develop and deliver safe, effective, evidence based services for the population of Milton Keynes.

Statement Milton Keynes Healthwatch

Healthwatch Milton Keynes would like to thank Milton Keynes University Hospital NHS Foundation Trust (MKUH) for inviting us to comment on the 2017/18 Quality Account.

The document is thorough and provides a clear overview of the initiatives implemented, and achievements against, the previous year's priorities and is transparent in acknowledging those areas that have not reached the goals set by MKUH. The account sets out clearly the priorities for the coming year and the measures that will be used to monitor these.

The report uses number of acronyms that are not listed in the glossary or explained within the main body of the text, e.g. MDT, M&M, ICE, SMH, PPH, and PICC. On page 143 of the report a paragraph ends in the middle of a sentence about the Event in the Tent, and there are variable uses of capital letters in mentions of this event, and of the Trust. The format changes part way through the reporting on local audits and subsequent formatting is difficult to follow.

The priorities, past and future, demonstrate a clear commitment to working more closely to the wider health and wellbeing system and acknowledges that the report is to enable patients and their carers to make well informed choices about their provider of healthcare.

It would be useful for the report to provide some justification for developing three new priorities, or a more rounded explanation of how the measures have improved things for the patient or staff group that were focused on. The performances against many of the prior year's targets are not achieving at the levels expected and, where they are, the results reflect a meeting of the internal KPIs, but not how this translates in relation to the patient or staff group, in practice.

For example, while the implementation of the measures has achieved the 2017/18 Priority 2 targets (although only in the first quarter of 2018), there is no mention of whether the numbers of stillbirths or early neonatal death in MK have reduced. If they have, it would be reassuring to see the numbers. If they have not, it would be worth noting what further work is being done to reduce these deaths, and why it was removed as a priority.

In Priority 3, it was encouraging to see the vast improvement in staff perception of the Trust's interest in their health and wellbeing. The rest of the numbers have stayed the same or slightly lowered and the report states that MKUH will continue to focus on this area however, there is no mention of how, or what will be done differently to grow the satisfaction rates of staff. As staff retention is a theme across the country, it is vital that MKUH have a robust plan for improvements in this area to ensure that the coming year's priorities can be achieved.

Throughout the report MKUH is very open and transparent about the issues faced, and there is an encouraging admission and acknowledgement of areas requiring improvement. It would be reassuring to readers of this report to be able to read plans for ways to support or encourage initiatives that provide a mechanism to monitor and report improvements.

Overall, we feel that the MKUH Quality Account reflects the great effort and energy being put in to improving services to patients, and future reports could benefit from being more explicit in the areas we have noted.

Statement from Milton Keynes Council Quality Account's Panel

Introduction

The Milton Keynes Quality Accounts Panel is of the view that MKUH's Quality Account 2017/18 is overall an improvement upon the previous year. Particularly outstanding are:-

- The clear explanation provided as regards MKUH's achievements in respect of its 2017/18 priorities, and when not achieved the clear explanation provided of measures implemented or to be implemented to address any performance shortcoming.
- The clear and strong justification provided for 2018/19 priorities.
- The progress made by MKUH in areas of research, and the clear and strong explanation provided of research's importance to the quality of MKUH's current and future service provision.
- The Contents (Page107) and Glossary (Page 160 – 163) which were clear and very helpful guides to navigating the Quality Account.

The Panel is however also of the view that the Quality Account as reflective of MKUH's planning, service delivery and performance could be improved. This is generally as regards:-

- Better comparisons and explanation of MKUH's performance relative to previous periods or benchmarked against national performance results.
- Greater information as regards MKUH's engagement with Healthwatch for example in facilitating Healthwatch's "enter and view" statutory power.
- Performance in respect of previous priorities. This would have shown that although MKUH's priorities for 2017/18 were somewhat different from that of 2016/17, performing against 2016/17 priorities were still important to MKUH.
- A better explanation as to the "Patient Experience" (Page 144), including greater detail as to the nature and reason for complaints received by MKUH, and the particular measures implemented or to be implemented for better complaint management and address.

The Panel is aware that MKUH's "Saving Babies' Lives Care Bundle" is considered best practice within the NHS. The Panel is therefore disappointed that this achievement was not included in the Quality Account, within which it would have added great value.

Quality Account - Commendations

The Panel is of the view that there are a number of things done by MKUH as reflected in the Quality Account that have to be especially commended:-

1. Chief Executive's Statement was informative, and very clear in the activities undertaken, being undertaken or to be undertaken by MKUH (Page 110 – 111).

2. Statement of Assurance (Page 112) which effectively outlines limitations in the data used by MKUH in preparing the Quality Account.

3. MKUH's commitment to not only provide a detailed narrative report on progress against goals in the 2018/19 Quality Account, but to also report progress to the Clinical Quality Board and Quality and Clinical Risk Committee (Page 115).

4. MKUH's acknowledgement that patient visits to the Outpatients Department will be the only hospital experience some people will have, and a declared MKUH goal of making such an experience positive (Page 115). The Panel looks forward to MKUH's reporting on performance against this goal in the 2018/19 Quality Account.

5. MKUH's 97% participation rate in national audits, 100% for national confidential enquiries for the 2017/18 period (Page 122) and the 51 local audits for 2017/18 (Page 126).

   Audits are a means of inspection and checking for problems with a view to them being solved. Audits are also key to strong governance and accountability frameworks. MKUH's strong Audit participation rate the Panel feels shows MKUH's appreciation of and value for such frameworks.

6. Attainment of second position in the "Thames Valley Research Network" (Page 128) is a notable achievement by MKUH.

   Research is an invaluable means by which the quality of NHS service provision can be improved. The Panel is of the view that MKUH's successful research performance among its NHS peers is laudable.

7. MKUH's investment efforts to improve data quality (Page 133) compliments the Trust's research focus. The Panel expects that this will greatly enhance the quality and effectiveness of MKUH's services in the future

   Progress and the results of this investment the Panel hopes will be reported on in future Quality Accounts.

8. Partnership working is an area wherein the Quality Account reveals MKUH is excelling. The Panel is impressed that MKUH has not restricted partnership working to within the NHS, but has been able to forge relationships with commercial partners for the purpose of research (Page 128).

9. The Quality Account reveals that for the 2017/18 period, MKUH had no conditions on its registration, and was not the subject of any CQC enforcement action (Page 130).

   The Panel is of the view that the above achievement reflects positively on MKUH as regards patient safety and care.

10. The Panel is heartened by MKUH's development of a "patient experience strategy" (Page 144).

    It is however hoped that this strategy will stress the importance of providing feedback as to treatment options to patients. As the strategy will be adopted in 2018/19, the Panel looks forward to it being reported on in future Quality Accounts.

11. The Panel congratulates MKUH for achieving 67% for the 2017/18 period, for "staff who would recommend the trust to their family and friends" (Page 137), which is above the national average of 61%. The Panel hopes that this result although positive will nonetheless be improved upon in subsequent Quality Accounts.

12. The Panel commends MKUH for its results in "Treating and caring for people in a safe environment and protecting them from avoidable harm" (Page 139).

13. MKUH's approach to its "Duty of Candour" (Page 141) as reflected in the Quality Account, is one which the Panel is highly supportive as a means to ensuring good quality patient care.

14. Although the Panel is disappointed that there were several "Never events" (Page 142) regarding which MKUH had to report. The Panel is pleased that there appears very clear and effective measures implemented or to be implemented so as to prevent similar occurrences in future.

Quality Account - Areas For Improvement

Notwithstanding the above achievements, the Panel is of the view that there is scope for improvement in the structure of the Quality Account and its outlining of the quality of MKUH's services. The Quality Account for example fails to provide adequate information of MKUH's services benchmarked against performance in previous periods or at the national level. Provision of this information would have allowed the Panel to make a more informed determination as to the quality of MKUH's services. For example:-

1. Although informing of 30 complaints received by MKUH about end of life care (Page 114), the Quality Account fails to provide a comparative as regards similar complaints in 2016/17.

2. Although the Quality Account outlines that "Preferred place of death is poorly documented" (Page 114), the Quality Account fails to provide a comparative in terms of time (previous periods), or performance relative to the national level.

3. The Quality Account outlines that 30,000 outpatient attendances had to be rescheduled or cancelled in 2017/18 (Page 115), and 13,000 patients were waiting longer than MKUH considered acceptable (Page 115). The Quality Account does not however provide a comparative in terms of MKUH's performance in previous periods or at the national level.

4. The Quality Account informs that since implementation of "fresh eyes metrics in July 2017" (Page 117), the Labour Ward has improved in performance. The Quality account however fails to provide information which could be used as a comparative for the Labour Ward's performance previously or at the national regional level.

5. The 2017 staff survey (Page 118) shows that MKUH has had mixed results in scores/ratings for staff engagement. What is clear to the Panel is that engagement measures employed by MKUH to date, have failed to bring about significant satisfaction for staff. This is concerning as the Panel believes it essential that staff within MKUH be satisfied with the extent and nature of engagement with them, owing to the positive effect this can have on staff morale and service provision.

   The Panel looks forward to the outcome of the "new initiatives and interventions" adopted by MKUH in 2017/18 (Page 118), being reported on in the 2018/19 Quality Account, so as to enable determination of the impact of these measures on staff.

6. The Panel congratulates MKUH for the "satisfactory" grade obtained for its Information Governance Assessment Report for 2017/18 (Page 121). It would however have been helpful if the Quality Account had provided benchmarking information as to grades on average received at the regional or national level. This would have helped the Panel to determine whether the "satisfactory" grade received by MKUH is indeed commendable.

In reviewing the various performance indicators, the Panel is concerned and disappointed that:-

7. MKUH delivered only 50% of this CQUIN as regards "Improvement of health and wellbeing of NHS staff" Indicator (Page 129).

8. MKUH's performance in the "timely identification of sepsis" Indicator, delivering only 25% of this CQUIN (Page 129), is extremely poor and is of great concern to the Panel. The Quality Account would benefit from additional information outlining what MKUH is doing to address this performance shortcoming, and so as assure stakeholders that performance will be improved for the future.

The Panel looks forward to the 2018/19 Quality Account wherein it is hoped that a significant improvement in performance for this Indicator will be reported by MKUH.

9. MKUH's failure to deliver upon NHS e-Referrals (Page 129).

10. Although MKUH delivered 55% for "Supporting Proactive and Safe Discharge" Indicator (Page 129), there is scope for improvement in delivery on this CQUIN.

11. The Panel considers it concerning that not all MKUH medical staff have completed the required level of safeguarding children's training.

    The Quality Account would have benefited greatly if it had been made clear how the current 90% compliance (Page 132) will be improved upon in going forward, and the Panel looks forward to MKUH's reporting on this matter in the 2018/19 Quality Account.

12. The Quality Accounts advises that MKUH had 5,123 patient safety incidents (Page 139), but a comparative time or national benchmark indicator is not provided by the Quality Account.

Further to the above outlined shortcomings in the Quality Account, the Panel also notes:-

13. MKUH's statement as regards the "National Reporting and Learning System" (Page 139) is not reader friendly, and it is recommended that this statement be reworded to bring about greater clarity.

14. MKUH's "Performance against key national priorities" (Page 145), and is disappointed that Indicators as relates to (i) Referral to treatment in 18 weeks (ii) Diagnostic wait under 6 weeks, (iii) A&E treatment within 4 hours, (iv) Cancelled operations, and (v) MRSA bacteraemia, for the 2017/18 period are all below national targets.

    The Panels is of the view that the Quality Account would benefit from a succinct explanation for these failures, and of measures to address these shortcomings.

15. MKUH has not provided 2017/18 data for a number of Indicators in the "Performance against key national priorities" table.

    The Panel is of the view that the Quality Account would benefit from a succinct explanation as to the failure or justification for non-provision of this data.

Conclusion

The Panel strongly commends MKUH as regards its 2017/18 Quality Account. It is hoped that in going forward successes outlined in the Quality Account will be further built upon by MKUH so as to excel in health service provision.

It is also hoped that areas wherein there is scope for improvement as highlighted by the Panel will be taken on board by MKUH to improve service delivery and its Quality Account reporting.

Statement from Central Bedfordshire Council Health Overview and Scrutiny Committee

- Central Bedfordshire's Social Care Health and Housing Overview and Scrutiny Committee welcomes the positive journey the hospital is taking to improve services for residents that includes a new cancer treatment centre and new children's A&E centre.
- The Committee looks to see more clarity and a measured improvement in the patient experience with the introduction the new patient strategy.
- That the hospital needs to focus on listening to its patients about their concerns and responding to them.

Annex 2
Statement of Directors' Responsibilities in Respect of the Quality Report

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to May 2018
  - Papers relating to quality reported to the Board over the period April 2017 to May 2018
  - Feedback from the commissioners dated May 2018
  - Feedback from governors dated 22 May 2018
  - Feedback from the local Healthwatch organisation dated 14 May 2018
  - Feedback from Local Authority dated May 2018
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, being reported to Trust Board in July 2017.
  - The national patient survey received in April 2018
  - The national staff survey results received in March 2018
  - The Head of Internal audit's annual opinion over the Trust's control environment dated May 2018
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the Board

25 May 2018 ..... Chairman

25 May 2018 ..... Chief Executive

Annex 3: Independent auditor's report to the council of governors of Milton Keynes University Hospital NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Milton Keynes University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Milton Keynes University Hospital NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Milton Keynes University Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting Milton Keynes University Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Milton Keynes University Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2017/18 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from the Commissioners dated 17 May 2018;
- feedback from the governors dated May 2018;
- feedback from local Healthwatch organisations, dated 14 May 2018
- feedback from Overview and Scrutiny Committee, dated May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2017;
- the national patient survey dated 31 May 2017;
- the national staff survey dated 6 March 2017;
- Care Quality Commission inspection dated 29 November 2016; and
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Milton Keynes University Hospital NHS Foundation Trust.

Basis for qualified conclusion

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator requires that the NHS Foundation Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in the national guidance. This is calculated as an average based on the percentage of incomplete pathways which are incomplete at each month end, where the patient has been waiting less than the 18 week target.

Our procedures included testing a risk based sample of 20 items and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- for 15% of items in our sample of patients' records tested, one or both of the start and end date of treatment were not accurately recorded, and affected the calculation of the published indicator.

- For a further 35% of sample items, one or both of the start and end date of treatment were not accurately recorded, but did not affect the calculation of the published indicator; and

As a result of the issues identified, we have concluded that there are errors in the calculation of the "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator for the year ended 31 March 2018. We are unable to quantify the effect of these errors on the reported indicator.

Percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge

The "percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator requires that the NHS Foundation Trust accurately record the start and end times of each patient's wait in A&E, in accordance with detailed requirements set out in the national guidance. This is calculated as a percentage of the total number of unplanned attendances at A&E for which patients' total time in A&E from arrival is four hours or less until admission, transfer or discharge as an inpatient.

Our procedures included testing a risk based sample of 20 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

In respect of the start time, we found that:

- for 25% of items in our sample of patients' records tested, the start of the wait time was not accurately recorded; and
- for 15% of items in our sample of patients' records tested, we were unable to obtain sufficient supporting evidence necessary to test the start time of the wait.

In respect of the end time, we found that:

- for 25% of sample items, the end time was not consistent with other Trust records; and
- for 25% of items in our sample of patients' records tested, we were unable to obtain sufficient supporting evidence necessary to test the end time of the wait.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator for the year ended 31 March 2018. We are unable to quantify the effect of these errors on the reported indicator.

The "Data Quality" section on page 143 of the NHS Foundation Trust's Annual Report details the actions that the NHS Foundation Trust is taking to resolve the issues identified in its processes.

Qualified conclusion

Based on the results of our procedures, except for the matters described in the basis for qualified conclusion section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2017/18 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.

Deloitte LLP

St Albans

25 May 2018

Appendix 1: Membership of the Council of Governors

		Constituency	No	Governors	Term of Office From	Term of Office To
PUBLIC (ELECTED)	A	Bletchley & Fenny Stratford, Denbigh, Eaton Manor & Whaddon	2	Peter Skingley	2 Sept 2016	1 Sept 2019
				Alan Hastings	3 June 2015	2 June 2018
	B	Emerson Valley, Furzton, Loughton Park	2	William Butler	26 Oct 2017	25 Oct 2020
				Douglas Campbell OBE	19 Mar 2015	13 Mar 2021
	C	Linford South, Bradwell, Campbell Park	2	Amanda Jopson	26 Oct 2017	25 Oct 2020
				Akin Soetan	14 Mar 2018	13 Mar 2021
	D	Hanslope Park, Olney, Sherington, Newport Pagnell	2	Liz Wogan	12 May 2009	11 May 2018
				Alan Hancock	1st Mar 2016	28 Feb 2019
	E	Walton Park, Danesborough, Middleton, Woughton	2	VACANT		
				Clare Hill	14 Mar 2017	13 Mar 2020
	F	Stantonbury, Stony Stratford, Wolverton	2	Carolyn Peirson	10 Nov 2015	9 Nov 2018
				Robert Johnson-Taylor	14 Mar 2017	13 Mar 2020
	G	Outer catchment area	2	Paul Griffiths	2 Sep 2016	1 Sep 2019
				Amanda Anderson	14 Mar 2018	13 Mar 2021
	H	Extended area	1	VACANT		
STAFF (ELECTED)	I	Doctors and Dentists	1	John Ekpa	14 Mar 2017	13 Mar 2020
	J	Nurses and Midwives	2	Kim Weston	1 Oct 2007	1 Sept 2019
				VACANT		
	K	Scientists, technicians and allied health professionals	1	Keith Marfleet	11 Oct 2012`	10 Oct 2018
	L	Non-clinical staff groups e.g. admin & clerical, estates, finance, HR, management	3	Lesley Sutton	11 Oct 2012	10 Oct 2018
				Laura Davison	1 Mar 2016	28 Feb 2019
				Marc Yerrell	14 Mar 2018	13 Mar 2021
APPOINTED	N	Milton Keynes Business Leaders	1	VACANT		
	O	Healthwatch MK	1	Ijeoma Ogbuju	2015	2018
	P	Community Action:MK	1	Maxine Taffetani	29 Aug 2017	28 Aug 2020
		Milton Keynes Council	1	Clare Walton	23 Aug 2017	22 Aug 2020
		Clinical Commissioning Group	1	Andrew Buckley	Aug 2016	Aug 2019
		Clinical Commissioning Group	1	Matt Webb	July 2014	July 2018
		Youth Cabinet	1	Jill Wilkinson	July 2014	July 2018

Appendix 2: Attendance at Council of Governor meetings

	16 May 2017	11 July 2017	12 September 2017	14 November 2017	23 January 2018	20 March 2018	All Meetings	NED appointments Committee
Amanda Anderson	N/A	**N/A**	N/A	N/A	N/A	X	**0**	
Buckley, Andrew	√	√	√	√	√	X	**5**	**5**
Butler, William	N/A	N/A	N/A	√	√	√	**3**	
Button, Jean	√	X	X	X	√	N/A	**2**	
Campbell, Douglas	√	X	√	X	X	X	**2**	
Davison, Laura	X	√	X	X	X	X	**1**	
Ekpa, John	X	√	X	X	√	√	**3**	
Georgestone, Arthur	√	X	X	N/A	N/A	N/A	**1**	
Gerrella, Philip	√	√	X	N/A	N/A	N/A	**2**	
Griffiths, Paul	√	X	X	√	X	X	**2**	
Hancock, Alan	√	√	√	√	√	√	**6**	
Hastings, Alan	X	√	√	√	√	√	**5**	**5**
Hill, Clare	√	X	X	√	X	X	**2**	
Johnson-Taylor, Robert	√	√	√	√	X	√	**5**	
Jopson, Amanda	N/A	N/A	N/A	√	√	X	**2**	
Lombardo, Mark	X	X	X	X	N/A	N/A	**0**	
Marfleet, Keith	N/A	√	X	√	√	√	**4**	
Nandi-purkayastha, Siddhartha	X	√	X	N/A	N/A	N/A	**1**	
Peirson, Carolyn	√	X	X	X	√	X	**2**	
Shah, Rohit	X	X	X	X	X	N/A	**0**	
Skingley, Peter	X	√	X	√	√	√	**4**	**5**
Soetan,Akin	N/A	N/A	N/A	N/A	N/A	√	**1**	
Sutton, Lesley	√	√	√	√	√	√	**6**	
Taffetani, Maxine	√	√	X	√	√	X	**4**	
Walton, Clare	N/A	√	X	√	X	X	**2**	
Webb, Matthew	√	X	X	X	X	X	**1**	
Weston, Kim	X	√	X	√	X	X	**2**	
Wogan, Liz	√	√	√	√	√	√	**6**	**5**
Marc Yerrell	N/A	N/A	N/A	N/A	N/A	X	**0**	

Appendix 3
Glossary

A & E	**Accident & Emergency**	hospital department specialising in the acute care of patients who arrive without a prior appointment
AHP	**Allied Healthcare Professional**	Generic term for professionals other than doctors and nurses who treat patients, therapists, physios, dieticians etc
ALOS	**Average Length of Stay**	the average amount of time patients stay in hospital
Amber	**Amber**	Projects will be assessed as having an overall risk rating of amber where it is considered that the project is not delivering to plan in respect of progress and/or impact, however, appropriate action is planned and/or is underway.
AO	**Accountable Officer**	A person responsible to report or explain their performance in a given area.
APR	**Annual Plan Return**	Submission of the annual plan to the regulator
BAF	**Board Assurance Framework**	Board document to assure the Board that risks to strategic priorities are being managed
BoD	**Board of Directors**	Executive Directors and Non-Executive Directors who have collective responsibility for leading and directing the foundation trust
Caldicott Guardian		Chief clinician who is held responsible for clinical record keeping (from Caldicott enquiry outcomes)
CAMHS	**Children and Adolescent Mental Health Services**	Specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties
CBA	**Cost Benefit Analysis**	A process for calculating and comparing the costs and benefits of a project.
CCG	**Clinical Commissioning Group**	Replaced Primary Care Trust. Led by local GPs to commission services
CDiff	**Clostridium difficile**	A bacterial infection that most commonly affects people staying in hospital
CDU	**Clinical Decisions Unit**	This is an integral part of the Emergency Department in a hospital, and it is used for patients who require a short period of observation or treatment, typically for a maximum of 24 hours.
CE/CEO	**Chief Executive Officer**	**Leads the day to day management of the Foundation Trust**
CF	**Cash Flow**	The money moving in and out of an organization
CGF	**Clinical Governance Facilitator**	Co-ordinates senior leadership team (doctor, nurse and manager) in new CSUs (replace HCFs.
CIP	**Cost Improvement Programme**	Also known as Transformation programme. This is a programme agreed by the trust at the start of the financial year, setting out the savings, usually from efficiencies, that it expects to make during the year.
CoA	**Chart of Accounts**	A list defining the classes of items against which money can be spent or received.
Code Victor		**Major Emergency Alert**
CoG	**Council of Governors**	The governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public
Common Front Door		Area where urgent care and A & E services can be co-located
CoP	**Code of Practice**	A set of regulations
CPD	**Continuing Professional Development**	Continued learning to help professionals maintain their skills and knowledge
CQC	**Care Quality Commission**	Regulator for clinical excellence
CQUIN	**Clinical Quality Incentive Scheme**	The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation.
CSU	**Clinical Service Units**	Business units in MK Hospital
CTG	**Cardiotocography**	a technical means of recording the fetus fetal pulse heartbeat
Datix		Risk management system
DD	**Due Diligence**	Is the term used to describe the performance of an investigation of a business or person
DGH	**District general hospital**	A medium sized hospital providing a range of services including an emergency department and the most common specialist services
DH/DoH	**Department of Health**	The ministerial department which leads, shapes and funds health and care in England
DIPC	**Director of Infection Prevention Control**	**A role required by law of all registered NHS care providers. The DIPC will have executive authority and responsibility for ensuring that strategies are in place to prevent avoidable healthcare associated infections**
DNA	**Did not Attend**	A patient who missed an appointment
DOC	**Doctor on call**	**A doctor, usually a general practitioner, who is contracted to provide care out of hours. In the hospital setting this could also refer to a Consultant who may be contacted out of hours for expert advice**
DOCC	**Department of Critical Care**	The Trust's intensive Care Unit
DoF	**Director of Finance**	The Board member leading on finance issues in the trust; an executive director
DOSA	**Day of Surgery Admission**	**When patients are admitted on the day of their surgery rather than the day before**
DPA	**Data Protection Act**	The law controlling how personal information is used
DTOCs	**Delayed Transfer of Care**	Patients who are medically fit but have not been discharged
Dr Foster		Benchmarking tool to assess relative performance
Duty of Candour		Consultation on including a contractual requirement for health providers to report and respond to incidents, apologise for errors etc
ED	**Executive Directors' (meeting)**	Semi-formal meeting of Executive Directors on Monday morning and Thursday afternoon
EDD	**Expected Delivery Dates**	The date that spontaneous onset of labour is expected to occur

EHR	**Electronic Health Record**	Health information about a patient collected in digital format which can theoretically be shared across different healthcare settings
ENP	**Emergency Nurse Practitioner**	**Specialist A&E nurse**
EOC	**Exec on Call**	The member of the executive or senior team who may be contacted out of hours where specific issues need to be escalated
EPR	**Electronic Patient record**	Also known as eCARE. The Trust's new system of managing and recording interactions patients electronically
ESR	**Employee Staff Record system**	**HR system in use**
FOI	**Freedom of Information**	**The right to ask any public sector organisation for the recorded information they have on any subject**
Formulary		Approved NHS list of prescribed drugs
FP10		Forms used to prescribe drugs to outpatients that they can pick up at the hospital pharmacy, rather than having to pay themselves
Francis Report		report into Mid Staffs hospital
FT	**Foundation Trust**	A part of the NHS in England that provides healthcare to patients/service users and has earned a degree of operational and financial independence
FTE	**Full Time Equivalent**	A measurement of an employees workload against that of someone employees full time e.g. 0.5 FTE would be someone who worked half the full time hours.
FTGA	**Foundation Trust Governors' Association**	National membership association for governors of NHS foundation trusts
FTN	**Foundation Trust Network**	The membership organisation and trade association for the NHS acute hospitals and community, mental health and ambulance services that treat patients and service users in the NHS
FY	**Financial Year**	The year used for accounting purposes, in the UK from 6 April to 5 April
GMC	**General Medical Council**	The independent regulator for doctors in the UK
GI	**Gastrointestinal**	Relating to the stomach and intestines
GMS	**General Medical Services**	Services provided by general practitioners under contract from NHS England
GP	**General Practitioner**	**Doctor who provides family health services in a local community**
Green		**Projects will be assessed as having an overall risk rating of green where it is considered that the project is delivering to plan in respect of progress and/or impact.**
GUM	**Genito-unitary medicine**	For sexually transmitted diseases/infections
HCA	**Healthcare Assistant**	staff working within a hospital or community setting under the guidance of a qualified healthcare professional
HCAI	**Healthcare Associated Infection**	These are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile are both classed as HCAIs

Healthwatch		Local independent health and social care critical friend
HEE	**Health Education England**	the NHS body responsible for the education, training and personal development of staff
HR	**Human Resources**	the department which looks after the workforce of an organisation e.g. Pay, recruitment, dismissal
HSCA	**Health and Social Care Act 2012**	an Act of parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
HSDU	**Hospital Sterile Decontamination Unit**	Part of Clinical Support Services CSU
HSMR	**Hospital Standardised Mortality Rate**	Number of deaths which is compared with other trusts
HWB/ HWBB	**Health and Wellbeing Board**	a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector
IBP	**Integrated Business Plan**	a strategy for connecting the planning functions of each department in a trust to align operations and strategy with financial performance
ICE	**Integrated Clinical Environment**	Web-based service used by pathology departments in around 60% of acute NHS Trusts to enable clinical requests to be made from wards, clinics and GP surgeries.
ICU	**Intensive Care Unit**	specialist unit for patients with severe and life threatening illnesses
Intrapartum		During childbirth (as opposed to pre-natal and post-natal)
IG	**Information Governance**	The legal framework governing the use of personal confidential data in healthcare
IP	**Inpatient**	**a patient who is hospitalised for more than 24 hours**
IT	**Information Technology**	**the study or use of systems(especially computers and telecommunications) for storing, retrieving and sending information**
Keogh Reviews		Reviews of Hospitals led by Sir Bruce Keogh, originally targeted hospitals with high mortality rates.
Kings Fund	**Kings Fund**	independent charity working to improve health and care in England
KPIs	**Key Performance Indicators**	indicators that help an organisation define and measure progress towards a goal
LD	**Learning Disabilities**	a disability which affects the way a person understands information and how they communicate
LETB	**Local Education and Training Board**	these are the local arms of Health Education England, now called by their region rather than LETB - e,g, training and workforce issues
LHE	**Local Health Economy**	the supply and demand of health care resources in a given area and the effect of health services on a population
LOS	**Length of Stay**	a term commonly used to measure the duration of a single episode of hospitalisation
M&M	**Mortality and morbidity meetings**	Meetings held, primarily within medical teams to analyse adverse outcomes in patient care, through peer review, and thereby learn from any errors and improve overall patient care
MDT	**Multidisciplinary Team**	A group of healthcare workers who are members of different disciplines each providing specific services to the patient.

MHA	**Mental Health Act**	the law in England and Wales that allows people with a 'mental disorder' to be admitted to hospital , detained and treated without their consent - either for their own health and safety, or for the protection of other people
MI	**Major Incident**	a major incident affects, or can potentially affect, hundreds or thousands of people and can cause a significant amount of casualties e.g. closure of a major facility due to fire, or persistent disruption of services over several weeks/months
MIU	**Minor Injuries Unit**	somewhere you can go to be treated for an injury that's not serious instead of going to A & E, e.g. For sprains, burns, broken bones
MKUHFT	**Milton Keynes University Hospital Foundation Trust**	Abbreviation of Milton Keynes University Hospital NHS Foundation Trust
MKUCS	**Milton Keynes Urgent Care Centre**	Consortium with GPs (40% owned by Trust) based in the hospital to alleviate A&E
MOC	**Manager on call**	A duty senior manager who may be called upon outside of normal working hours to act or authorise action in response to an incident or other specified occurrence.
Monitor	**Monitor**	Independent body responsible for the regulation of NHS foundation trusts. Its functions are now performed by NHS Improvement
Morbidity	**Morbidity**	the proportion of sickness or of a specific disease in a geographical locality.
Mortality	**Mortality**	the relative frequency of deaths in a specific population; death rate.
MoU	**Memorandum of Understanding**	An agreement between 2 or more parties indicating a common line of action
MRI	**Magnetic Resonance Imaging**	a medical imaging technique
MRSA	**Methicillin-Resistant Staphyloccus Aureus**	a bacterium responsible for several difficult-to-treat infections in humans
MSA	**Mixed Sex Accommodation**	wards with beds for both male and female patients
MUST	**Malnutrition Universal Screening Tool**	MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
NE	**Never Event**	It is for use in hospitals, community and other care settings and can be used
NED	**Non-Executive Director**	by all care workers.
NHS	**National Health Service**	A list of serious medical errors or adverse events, such as wrong site surgery, that should never happen to a patient
NHS Direct	**NHS Direct**	An often independent member of the board of directors of an NHS trust, who is not an employee of the trust, but is nevertheless partly responsible for its running.
NICU	**Neonatal Intensive Care Unit**	publicly funded healthcare system with the UK
NHSLA	**NHS Litigation Authority**	24-hour telephone helpline and website providing confidential information on health conditions local healthcare services, self help and support organisations
NHSTDA	**NHS Trust Development Authority**	This unit treats babies and infants with a variety of serious medical and surgical conditions that require intensive care support.
NICE	**National Institute for Health and Care Excellence**	Manages Clinical Negligence Scheme for Trusts
NMC	**Nursing and Midwifery Council**	provide governance and accountability for NHS trusts in England and delivery of the foundation trust pipeline
NRLS	**National Reporting and Learning System**	provides national guidance and advice to improve health and social care
NSfs	**National Service Frameworks**	nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands
OP	**Outpatients**	Database for recording patient safety incidents (held by MPSA)
OSCs	**Overview and Scrutiny Committees**	set clear quality requirements for care
PA	**Programmed Activities**	a patient who is not hospitalised for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment
PALS	**Patient advice and liaison service**	established in local authorities by the Local Government Act 2000 to develop and review policy and make recommendations to the council
PbR	**Payment by Results or 'tariff'**	4 hour blocks that are used to make up a consultant's contract.
PDR	**Personal Development Review**	You can talk to PALS who provide confidential advice and support to patients, families and their carers, and can provide information on the NHS and health related matters.
PFI	**Private Finance Initiative**	a way of paying for services that gives a unit price to a procedure
PLACE	**Patient-Led Assessments of the Care Environment**	Appraisal system
PICC	**Percutaneous indwelling central catheter**	a scheme where private finance is sought to supply public sector services over a period of up to 60 years
POA	**Pre-operation assessment**	local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food cleanliness and general building maintenance
PPH	**Postpartum haemorrhage**	A form of intravenous access that can be used for a prolonged period of time (for example for long chemotherapy regimens or antibiotic therapy
PPI	**Patient and Public Involvement**	A history and physical examination focusing on risk factors ahead of surgery

PROM	**Patient Reported Outcome Measures**	Heavy bleeding after childbirth, often defined as the loss of more than 500ml or 1000ml of blood within the first 24 hours following childbirth
Productive Ward		mechanisms that ensure that members of the community - whether they are service users, patients or those who live nearby - are at the centre of the delivery of health and social care services
PTS	**Patient Transport Services**	A system which measures health gain in patients undergoing hip and knee replacement surgery, and previously varicose vein and groin hernia surgery
QA	**Quality Assurance**	Initiative to streamline operation of wards - included in Maternity Development Plan, due to be rolled out across the hospital
QGAF	**Quality Governance Assurance Framework**	free transport to and from hospital for non-emergency patients who have a medical need
QIPP	**Quality, Innovation, Productivity and Prevention**	monitoring and checking outputs and feeding back to improve the process and prevent errors
Quality Accounts		assess the combination of structures and processes in place, both at and below board level, which enable a trust board to assure the quality of care it provides
RAG	**Red, Amber, Green classifications**	12 work streams to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements.
RCA	**Root cause analysis**	An annual report to the public from providers of NHS healthcare services about the quality of their services
RCGP	**Royal College of General Practitioners**	professional membership body of GPs
RCP	**Royal College of Physicians**	A method of problem solving used for identifying the root causes of faults or problems
RCS	**Royal College of Surgeons**	professional membership body representing surgeons
R&D	**Research & Development**	professional membership body for doctors
Red		professional membership organization representing surgeons
RGN	**Registered General Nurse**	developing new products or processes to improve and expand
RTT	**Referral to treatment**	Projects will be assessed as have an overall risk rating of red where it is considered that the project is not being delivered as planned in respect of progress and/or impact.
Rule 43		a nurse who is fully qualified and is registered with the nursing and Midwifery Council as fit to practice
SFI	**Standing Financial Instructions**	Used as part of the 18 week indicator
SHMI	**Summary Hospital Level Mortality Indicator**	Issued by Coroners to organisations. Must be responded to within 56 days. Lord Chancellor's office keep a record of all rule 43s issued
SI	**Serious incident**	Found on the intranet under 'Trust Policies'
SID	**Senior Independent Director**	reports mortality at trust level across the NHS in England using standard and transparent methodology
SIRG	**Serious incident Review Group**	A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care
SLM	**Service Line Management**	a non-executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair
SLA	**Service Level Agreement**	to review serious incidents and identify learning points
SLR	**Service Line Reporting**	A framework for the delivery of clinical services
SRR	**Significant risk register**	an agreement between two or more parties
T&C	**Terms and conditions**	A reporting system which by comparing income against expenditure gives a statement of profitability at service line level
TDA	**Trust Development Authority**	Risks scored 15 and over
T&O	**Trauma & Orthopaedics**	set the rights and obligations of the contracting parties, when a contract is awarded or entered into
TTO	**To Take Out**	Regulator for Non foundation trusts. Its functions are now provided by NHS Improvement
VTE	**Venous thromboembolism**	Hospital department that diagnoses and treats a wide range of conditions of the musculoskeletal system
WiC	**Walk in Centre**	Medicines given to discharging patients
WTE	**Whole time employees**	Blood clotting, usually caused by inactivity. Should be assessed for routinely to ensure care pathways take into risk
YTD	**Year to Date**	Provided jointly with the hospital and local GPs under a commercial arrangement as the Urgent Care Centre
WTE	**Whole time employees**	Member of staff contracted hours for full time
YTD	**Year to Date**	a period, starting from the beginning of the current year and continuing up to the present day. The year usually starts on 1st January

Appendix 4
Annual Accounts 2017/18

Milton Keynes University Hospital NHS Foundation Trust
Accounts Year Ended 31 March 2018

Statement of the chief executive's responsibilities as the Accounting Officer of Milton Keynes University Hospital NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the National Health Service Act 2006, has given accounts directions which require Milton Keynes University Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Milton Keynes University Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Joe Harrison
CHIEF EXECUTIVE

Date: 25th May 2018

Independent Auditor's Report to the Council of Governors and Board of Directors of Milton Keynes University Hospital NHS Foundation Trust

Report on the audit of the financial statements

In our opinion the financial statements of Milton Keynes University Hospital NHS Foundation Trust (the 'foundation trust'):

- **give a true and fair view of the state of the foundation trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:
- the statement of comprehensive income;
- the statement of financial position;
- the statement of cash flows;
- the statement of changes in taxpayers' equity; and
- the related notes 1 to 24.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty relating to going concern

We draw attention to note 1.1 in the financial statements, which indicates that the foundation trust incurred a net deficit of £16.1m during the year ended 31 March 2018, and has identified that that additional funding is required before the end of 2018/19 to support the foundation trust in meetings its liabilities which is yet to be formally agreed. Without additional funding, the foundation trust will have insufficient working capital to meet its liabilities as they fall due.

In addition, the Trust's working capital requirement is dependent on uncertainties over cash flows including receipt of the Provider Sustainability Funding which is dependent on meeting performance targets and the foundation trust achieving its efficiency savings plan. Also, the foundation trust has a further existing loan of £31.2m falling due in March 2019 where the facility is yet to be extended. If the foundation trust did not receive an extension to the existing loan, or experiences a shorfall in forecast cashflows, it would have to apply for alternative funding from the Department of Health. The outcome of such an application is currently uncertain.

In response to this, we:
- reviewed the foundation trust's financial performance in 2017/18 including its achievement of planned cost improvements in the year;
- held discussions with management to understand the current status of the funding arrangements that have been agreed, confirming to signed loan agreements and regarding management's expectation around further funding requirements;
- reviewed the foundation trust's cash flow forecasts and the foundation trust's financial plan submitted to NHS Improvement;
- challenged the key assumptions used in the cash flow forecasts by reference to NHS Improvement guidance; and
- assessed the historical accuracy of the budgeting process used by the foundation trust.

As stated in note 1.1, these events or conditions, along with the other matters as set forth in note 1.1 to the financial statements, indicate that a material uncertainty exists that may cast significant doubt on the foundation trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Summary of our audit approach

Key audit matters The key audit matters that we identified in the current year were:

- NHS revenue and provisions
- Going concern (see material uncertainty relating to going concern section)
- Arrangements to secure value for money (see matters on which we are required to report by exception – use of resources section)

Within this report, any new key audit matters are identified with and any key audit matters which are the same as the prior year identified with .

Materiality The materiality that we used for the current year was £4.2m which was determined on the basis of revenue.

Scoping Audit work was performed at the Trust's head offices in Milton Keynes directly by the audit engagement team, led by the audit partner.

Significant changes in our approach Significant changes in our approach

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

In addition to the matter described in the material uncertainty relating to going concern section and the matter described in the matters on which we are required to report by exception – use of resources section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Key audit matter description As described in note 1, Accounting Policies and other information, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to the judgemental nature of provisions for disputes, including in respect of outstanding overperformance income for quarters 3 and 4.

Details of the foundation trust's income, including £197m (2017: £187m) of Commissioner Requested Services, are shown in note 2.1 to the financial statements. NHS receivables of £19m (2017: £17m), form part of trade receivables and accrued income in note 12 to the financial statements.

The majority of the foundation trust's income comes from three commissioners, NHS Milton Keynes, NHS England and NHS Bedfordshire, increasing the significance of associated judgements. The settlement of income with Clinical Commissioning Groups continues to present challenges, leading to disputes and delays in the agreement of year end positions.

How the scope of our audit responded to the risk We evaluated the design and implementation of controls over recognition of NHS income.

We performed detailed substantive testing on a sample basis of the recoverability of unsettled revenue amounts, and evaluated the results of the agreement of balances exercise.

We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.

Key observations Based on the work performed we concluded that the revenue and provisions recognised are appropriate

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality	£4.2m (2017: £3.8m)
Basis for determining materiality	1.8% of revenue (2017: 1.8% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £210,000 (2017: £190,000), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's head offices in Milton Keynes directly by the audit engagement team, led by the audit partner. The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems.

The Trust makes use of NHS Shared Service, a service organisation, for its financial processing activities. We have reviewed reports prepared by the service organisation and performed procedures on information available at the Trust.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, including the performance report, the accountability report and the explanatory foreword, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities , the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources
We are required to report to you if, in our opinion the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion
On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in December 2017, with the exception of the matters reported in the basis for qualified conclusion section, below, we are satisfied that, in all significant respects, Milton Keynes University Hospital NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion
The Trust has continued its programme of work to improve governance arrangements over data quality and the quality of data itself. Because of the timing of this work, key improvements to arrangements which the Trust has described in the Annual Governance Statement have not operated for all or substantially all of the year or applied to all key data sets.

In our "Limited assurance report on the content of the quality report and mandated performance indicators", we issued a qualified conclusion because of errors identified in the calculation of the 18 week Referral-to-Treatment and Accident and Emergency 4 hour wait performance indicators.

These issues are evidence of weaknesses in proper arrangements for understanding and using appropriate and reliable performance information to support informed decision making and performance management.

The foundation trust incurred a deficit of £16.1m for the year ended 31 March 2018, within the control total agreed with NHSI. The foundation trust's 2018/19 plan submission in March 2018 showed a forecast deficit of £15.8m for 2018/19 before capital donations of £7.9m and after Provider Sustainability Funding of £10.3m.

In order to fund these deficits, the directors received financial support in 2017/18 of an £18.8m revenue support loan and a £4.8m capital support loan from the Department of Health and is seeking financial support in 2018/19 of £15.8m Interim Revenue Support Loan and £11.3m Interim Capital Support Loan from the same source as well as the extension of a loan of £31.2m which is due for repayment in March 2019.

These issues are evidence of weaknesses in proper arrangements to support the sustainable delivery of strategic priorities and maintain statutory functions.

Annual Governance Statement, use of resources, and compilation of financial statements
Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator
Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors and Board of Directors ("the Council and Board") of Milton Keynes University Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council and Board those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the foundation trust and the Council and Board as a body, for our audit work, for this report, or for the opinions we have formed.

Jonathan Gooding FCA
SENIOR STATUTORY AUDITOR

FOR AND ON BEHALF OF DELOITTE LLP
STATUTORY AUDITOR
ST ALBANS, UNITED KINGDOM

25 May 2018

Foreword To The Accounts

Milton Keynes University Hospital NHS Foundation Trust

Milton Keynes University Hospital NHS Foundation Trust ("the Trust") acts as an acute Hospital for Milton Keynes.

These accounts for the year ended 31 March 2018 have been prepared by Milton Keynes University Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the 2006 Act

Joe Harrison
CHIEF EXECUTIVE

Date: 25 May 2018

Statement of Comprehensive Income For the Year Ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	2.1-2.5	200,891	190,445
Other operating income	2.2	26,744	24,868
Total operating income from continuing operations		**227,635**	**215,313**
Operating expenses	3-6	(240,237)	(232,481)
		(12,602)	**(17,168)**
FINANCE COSTS			
Finance income	7.1	19	19
Finance expenses	7.2	(1,770)	(1,664)
PDC dividends payable		(1,715)	(2,271)
NET FINANCE COSTS		**(3,466)**	**(3,916)**
Loss on disposal of assets		(28)	(21)
(DEFICIT) FOR THE YEAR		**(16,096)**	**(21,105)**
Other Comprehensive Income			
Will not be reclassified subsequently to surplus or deficit:			
Impairments		0	(4,974)
Revaluations		8,118	10,634
Total other comprehensive income		8,118	5,660
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(7,978)**	**(15,445)**

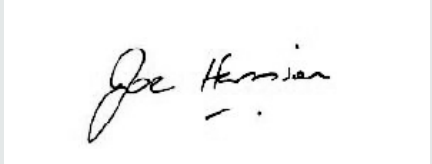
The notes to the accounts are on pages 178-203.

Statement of Financial Position As at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
NON-CURRENT ASSETS			
Intangible assets		10,054	5,724
Property, plant and equipment	9	171,862	160,382
Trade and other receivables	12	405	275
TOTAL NON-CURRENT ASSETS		**182,321**	**166,381**
CURRENT ASSETS			
Inventories		3,257	3,044
Trade and other receivables	12	23,223	19,786
Cash and cash equivalents	13	2,507	3,906
TOTAL CURRENT ASSETS		**28,988**	**26,736**
CURRENT LIABILITIES			
Trade and other payables	14.1	(28,333)	(26,224)
Deferred Income	14.2	(1,637)	(1,625)
Borrowings	15	(32,298)	(32,319)
Provisions	17	(1,381)	(3,087)
TOTAL CURRENT LIABILITIES		**(63,649)**	**(63,255)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**147,660**	**129,862**
NON-CURRENT LIABILITIES			
Borrowings	15	(83,605)	(61,077)
Provisions	17	(1,142)	(893)
TOTAL NON-CURRENT LIABILITIES		**(84,747)**	**(61,970)**
TOTAL ASSETS EMPLOYED		**62,912**	**67,892**
FINANCED BY			
Public dividend capital		99,154	96,157
Revaluation reserve		78,667	70,549
Income and expenditure reserve		(114,909)	(98,814)
TOTAL TAXPAYERS' EQUITY		**62,912**	**67,892**

The Financial Statements and notes on pages 178-203 were approved by the Board and authorised for issue on 25 May 2018 and signed on its behalf by:

Simon Lloyd
CHAIRMAN



Joe Harrison
CHIEF EXECUTIVE

Mike Keech
DIRECTOR OF FINANCE

Statement of Changes in Taxpayers' Equity For The Year Ended 31 March 2018

		Public Dividend Capital	Revaluation Reserve	Income & Expenditure Reserve	Total
		£000	£000	£000	£000
TAXPAYERS' AND OTHERS' EQUITY AT 1 APRIL 2017		**96,157**	**70,550**	**(98,814)**	**67,893**
Deficit for the year		0	0	(16,096)	**(16,096)**
Revaluations		0	8,118	0	**8,118**
Public Dividend Capital received		2,997	0	0	**2,997**
TAXPAYERS' AND OTHERS' EQUITY AT 31 MARCH 2018		**99,154**	**78,668**	**(114,910)**	**62,912**
TAXPAYERS' AND OTHERS' EQUITY AT 1 APRIL 2016		**96,157**	**64,890**	**(77,709)**	**83,338**
(Deficit) for the year		0	0	(21,105)	**(21,105)**
Impairments		0	(4,974)	0	**(4,974)**
Revaluations	7.3	0	10,634	0	**10,634**
TAXPAYERS' AND OTHERS' EQUITY AT 31 MARCH 2017		**96,157**	**70,550**	**(98,814)**	**67,893**

Statement of Cash flows For the Year Ended 31 March 2017

	2017/18 £000	2016/17 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating (deficit) from continuing operations	(12,602)	(17,168)
OPERATING (DEFICIT)	**(12,602)**	**(17,168)**
NON-CASH INCOME AND EXPENSE:		
Depreciation and amortisation	9,036	8,878
Impairments and reversals of impairments	0	242
Income recognised in respect of capital donations (cash and non-cash)	(75)	(13)
(Increase) in receivables and other assets	(3,567)	(8,468)
(Decrease) in inventories	(213)	(76)
Increase in payables	413	2,443
Increase in other liabilities	13	98
(Decrease)/Increase in provisions	(1,457)	1,137
Other movements in operating cash flows	74	(16)
NET CASH (USED IN) OPERATING ACTIVITIES	**(8,378)**	**(12,943)**
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	19	19
Purchase of intangible assets	(5,557)	(2,217)
Sale of Intangible Assets	24	105
Purchase of property, plant, equipment	(9,628)	(7,465)
Sale of property, plant & equipment	44	657
Receipt of cash donations to purchase capital assets	75	13
NET CASH (USED IN) INVESTING ACTIVITIES	**(15,023)**	**(8,888)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Public dividend capital received	2,997	0
Loans Repaid to the Department of health	(953)	(15,803)
Loans Received from the Department of Health	23,625	42,779
Capital element of finance lease rental payments	(162)	(57)
Interest paid on finance lease liabilities	(1,448)	(335)
Other interest paid	(322)	(1,196)
PDC dividend paid	(1,735)	(2,154)
NET CASH GENERATED FROM FINANCING ACTIVITIES	**22,002**	**23,234**
(DECREASE) IN CASH AND CASH EQUIVALENTS	**(1,399)**	**1,403**
CASH AND CASH EQUIVALENTS AT 1 APRIL	**3,906**	**2,503**
CASH AND CASH EQUIVALENTS AT 31 MARCH	**2,507**	**3,906**

Notes to the Accounts

1. Accounting policies and other information

These accounts for the year ended 31 March 2018 have been prepared by the Trust in accordance with the National Health Service Act 2006.

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Operating Segments

The Board of Directors are of the opinion that the Trust's operating activities fall under the single heading of "Healthcare" for the purposes of segmental reporting in accordance with International Financial Reporting Standard 8.

Consolidation

From 1 April 2014, the NHS has had to apply IFRS10,'Consolidated Financial Statements' in respect of consolidating Charitable Funds. The Trust has reviewed the criteria under IFRS10 and it meets the criteria in respect of having an interest and control of MK Hospital NHS charity and it directly benefits from the activities of the charitable funds. However, it has not consolidated the charitable funds into these accounts because the trust does not consider it to be material. The Charitable fund's income and expenditure represents only 0.2% of the Trusts position so they are not material to the accounts of the Trust. The Trust set up a subsidiary during the year, ADMK Ltd, however there have been no activities during 2017/18.

From the 1 April 2014, the NHS has applied IFRS 11, 'Joint Arrangements' and IFRS12, 'Disclosure of Interests in Other Entities,' however the Trust has decided not to consolidate the Milton Keynes Urgent Care Services into these accounts due to this position not being material to the Trusts accounts. See Note 10.

Critical Judgements and Key Sources of Estimation Uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from the estimates, but the underlying assumptions are regularly updated. Revisions to accounting estimates, which only affect that period, are recognised in the period in which the estimate is revised. If the revision affects both current and future periods it is recognised in the period of the revision and future periods.

Critical judgements in applying accounting policies:

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Valuations of Land and Buildings

The most significant estimate within the accounts is the value of land and buildings. In accordance with International Accounting Standards, a full property valuation is carried out on the Trust's land and buildings every five years, with an interim valuation after three years. The Trust has as at the 31st March 2018, undertaken a director valuation after taking advice on suitable indices to apply to reflect changes in the building costs and local land price movements since the date of the last valuation. As a result, it has estimated that there has been in increase in the value of its assets by £8.1m which has reflected as an increase in non-current assets.

An interim valuation was undertaken as at 31st March 2017 and a full revaluation is due March 2020.

The district valuer is independent of the Trust and is certified by the Royal Institute of Chartered Surveyors. The valuer, who performed the last external valuation, has extensive knowledge of the physical estate and market factors.

Key sources of estimation uncertainty

The following are the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting year, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Valuations of Land and Buildings

Valuations do not take into account future potential changes in market value which cannot be predicted with any certainty therefore, between valuations, management reviews the values for any material changes and make judgements about market changes and assesses whether the carrying amount does not differ materially from that which would be expected using fair value at the end of the reporting period. The management review of estate values carried out in 2017/18 resulted in an overall increase in the revaluation reserve of £8.1m.

1.1 Basis of accounting – going concern

IAS 1 requires management to undertake an assessment of the NHS Foundation Trust's ability to continue as a going concern. These accounts have been prepared on a going concern basis as there has been no application to the Secretary of State for the dissolution of the NHS Foundation Trust and the Directors currently believe there is a realistic alternative to doing so. The Directors have therefore prepared these financial statements on a going concern basis.

The current financial environment for all NHS Trusts and NHS Foundation Trusts continues to be challenging with trusts having to deliver recurrent efficiencies in order to combat inflationary pressures and meet financial control totals set by regulators.

For the year ended 31 March 2018 the Trust has a financial deficit of £16.1m (£21.1m deficit for the year ended 31 March 2017) and delivered an improved position against the financial control total set by NHS Improvement by £0.3m. However, the Directors consider that the outlook presents significant challenges given the need to deliver on-going efficiency, as well as the Trust's reliance on borrowing from the Department of Health and Social Care to support its cash flow.

The Trust has prepared its financial plans and cash flow forecasts on the assumption that adequate funding will be received from the Trust's commissioners (contractual income), and through Department of Health and Social Care (DHSC) funding facilities. In addition, the Trust has assumed it will receive £10.3m of non-recurrent Provider Sustainability Funding (PSF), the payment of which is contingent on the Trust achieving its agreed financial control total and meeting its agreed performance trajectories during 2018/19.

The Trust expects this to be sufficient to prevent the Trust from failing to meet its obligations as they fall due, and to continue operating until adequate plans are in place to achieve financial sustainability for the Trust. However, the Directors have identified that there are material uncertainties that cast significant doubt over whether the Trust will continue to exist in its current form, and over its ability to discharge its liabilities in the normal course of business.

Funding for the 2018/19 financial year over and above internal generating funds is still to be determined; however it is expected to be through uncommitted revenue/capital term loans as in previous years. This will have the effect of increasing long term liabilities and reducing net assets. The revenue loan facilities have a maturity of 3 years, with no principal being repaid until the end of the term. Capital loan financing is expected to be repaid over a 10 year period.

As part of its 2018/19 financial plan submission, the Trust has requested revenue support of £15.8m and a further £11.3m for capital expenditure (of which £4.7m has been pre-approved by DHSC). In addition the Trust has a revenue loan of £31.2m whose repayment term has been extended until March 2019. The Trust is waiting further information from DHSC that the loan's repayment period will be extended further.

Positive cash balances can only be maintained throughout the period by successfully securing the necessary funding from DHSC, having a contract with the lead commissioner Milton Keynes Clinical Commissioning Group and receiving 10.3m of PSF.

The significant risks facing the Trust are summarised as follows:

1. The Trust has prepared a cash flow forecast which shows a minimum daily level of headroom of £1m. There is a level of uncertainty over whether the Trust will receive additional uncommitted loans of £15.8m (revenue) for 2018/19 as well as £3.6m for the period April 19 to June 19 and £11.3m (capital) required to meet its financial obligations.

   In addition there is uncertainty around the amount of PSF the Trust may receive due to funding being split between achievement of the following three elements: the Trust's financial control total; the ICS's control total; and achievement of the A&E targets. However, the Trust has developed its financial plan assuming that it will receive this funding, as well as rolling over existing loans that are due for repayment within the next 12 months, and thus continue on a going concern basis;

2. There is uncertainty over whether the Trust will achieve its efficiency savings plan (circa £10m). This is a level of savings which is extremely challenging and must be supported with adequate clinical focus and engagement in quality process improvement against agreed and appropriately detailed delivery plans.

3. The rate of growth in the hospital's catchment population is expected to be above the national average. If actual growth rates exceed those assumed in the Trust's 2018/19 financial plan, there is a two-fold risk: firstly in the Trust's commissioners' ability to pay for higher levels of activity and secondly in the cost of resourcing unplanned activity.

4. The implementation (planned May 2018) of the Trust's electronic patient record system (eCare) could lead to adverse impacts on the Trust's finances or performance during the transition phase.

5. There remains uncertainty around the potential impact of macroeconomic factors, including those associated with 'Brexit'.

While there are material uncertainties which may cast significant doubt as to the Trust's ability to continue as a going concern and therefore its ability to realise its assets and discharge its liabilities in the normal course of business, the financial statements do not include any adjustments that would result if the going concern basis were not appropriate.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Income relating to patient care spells that are part-completed at the year-end is apportioned across the financial years on the basis of the number of occupied beds, applied to the cost per spell or average cost per spell per speciality where the spell cost was not directly available.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The Trust receives income under the NHS Injury Cost recovery Scheme. This is designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid for example by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pensions compensation recovery unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual less a provision for the unsuccessful compensation claims and doubtful debts.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

1.4 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that, the goods or services have been received. It is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of non-current assets such as property, plant and equipment.

1.5 Expenditure on employee benefits

Short –term employee benefits

Salaries, wages and employment-related payments, including termination benefits, are recognised in the period in which the service is received from employees. Annual leave entitlement is actively encouraged to be taken in the year that it is earned, however there are exceptional circumstances when the annual leave entitlement may be carried forward into the following year. Untaken leave is accrued on an average five days carry forward for medical staff, excluding junior doctors and registrars in training. All other staff are accrued based on annual data collection of untaken hours applied to their hourly rate of pay. The cost of this annual leave entitlement earned but not taken at the end of the financial year is recognised in the financial statements.

Pension costs-NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

Employer Contributions

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Scheme Liabilities

The liabilities of the pension scheme as at 31 March 2016 were £509.4 billion. The national deficit of the scheme was £10.3 billion as per the last scheme valuation by the Government Actuary as at 31 March 2012. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis. Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. Tiered employer contribution rates were recommended and those applicable from the 1 April 2014 were: a lower limit of 5% and an upper limit of 14.5% of pensionable pay. Employers' pension cost contributions are charged to operating expenses as and when they become due. The expected value of the trusts employer's pension contributions for 2018/19 is £14.1m (£12.9m 2017/18)

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Pension costs-NEST Pension Scheme

From the 1 October 2013 the Trust has participated in the Government's Auto Enrolment Pension scheme. It has auto-enrolled those employees who are not eligible for the NHS Pensions scheme into an alternative pension scheme run by National Employers Savings Trust (NEST).

The employer's contributions for all eligible staff are 1% in the first year, rising to 3% by 2018. For employees who are eligible for the NHS Pensions scheme the Trust had a transitional date of 2017 which was agreed with the Pensions Regulator. The Trust currently has, at the 31 March 2018, 56 employees enrolled into NEST and the employers contributions for the current financial year have been £10k.

1.6 Property, Plant and Equipment

Recognition

Property, Plant and Equipment (PPE) is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably and
- the item has a cost of at least £5,000, or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, and are anticipated to have simultaneous disposal dates and are under single managerial control

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

The Trust capitalises assets that individually have a cost of at least £5,000 or form a group of assets which individually have a cost of more than £250 and collectively have a cost of at least £5,000, where the assets are: functionally interdependent; have broadly simultaneous purchase dates; are anticipated to have simultaneous disposal dates and are under single managerial control.

Assets will also be capitalised if they form part of the initial set-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost. In accordance with IAS23, borrowing costs directly attributable to the financing of PPE are also capitalised up until all the activities necessary to prepare the asset for its intended use are complete.

Where a large asset, for example a building, includes a number of components with significantly different lives such as plant and equipment, these components are treated as separate assets and are depreciated over their individual useful economic lives.

Valuation

All property, plant and equipment assets are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at current value.

The carrying value of fixtures and equipment are written off over the remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

Land and buildings are re-valued where a movement in current values is considered to be material. Current values are determined as follows:

- Land and non-specialised operational assets – Existing use value.
- Specialised assets – depreciated replacement cost applying the modern equivalent asset principle.

HM Treasury adopted a standard approach to depreciated replacement cost valuations on a modern equivalent asset where it would meet the location requirements of the service being provided; an alternative site can be valued.

In any event, professional valuations are carried out every five years, together with a three year interim/desk top valuation. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Standards Manual.

The Trust has as at the 31st March 2018, undertaken a director valuation after taking advice from a RICS qualified valuer from District Valuer Services (DVS) on suitable indices to apply, to reflect changes in the building costs and local land price movements since the date of the last valuation. As a result, it has estimated that there has been in increase in the value of its assets by £8.1m which has been reflected as an increase in non-current assets. An interim valuation was undertaken by DVS as at 31st March 2017 and a full revaluation is due March 2020.

The DVS is the commercial arm of the Valuation Office Agency, which is an executive agency of HM Revenue & Customs (HMRC). It provides professional property advice across the public sector in England, Wales and Scotland.

Buildings are valued at depreciated replacement cost on a modern equivalent asset basis for buildings which qualify as a specialised operational property asset which is consistent with IAS16, with regard to the suitable indices that reflect changes in the building costs.

Non specialised operational property, including land, is assessed at existing use value whilst non-operational property, including surplus land is valued on the basis of market value. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Until 31 March 2008, plant, machinery, vehicles, furniture and fittings were carried at replacement cost, based on indexation and depreciation of historic cost. New assets are carried at depreciated historic cost, unless this is considered to be materially different from fair value due to significant volatility in asset values.

Subsequent Expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replace is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, dwellings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset based on assessments by the Trust's professional valuers. Leasehold buildings are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the following estimated lives:

Asset Category	Estimated life (in years)
Buildings excluding dwellings	8 to 90
Dwellings	40
Plant and Machinery	5 to 20
Transport Equipment	7
Information Technology	2 to 8
Furniture and Fittings	5 to 10
Leased assets	Over the lease term

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve except where, and to the extent that, they reverse a revaluation decrease that has been previously recognised in operating expenses, In which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent there is an available balance for the asset concerned and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to the operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised as operating income to the extent that the asset is restored to its carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains. Where impairment arises from a clear consumption of economic value, this is taken in full to operating expenses.

De-recognition

Assets intended for disposal, are reclassified as 'Held for sale' once all the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sale;
- the sale must be highly probable; i.e.
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale';

  and
  - the actions needed to complete the sale indicate it is unlikely that the sale will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not re-valued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential will be provided, to the Trust where the cost of the asset can be measured reliably.

Internally Generated

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised and is recognised as an operating expense in the period that it is incurred.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the trust intends to complete the asset and sell or use it;
- the trust has the liability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial , technical and other resources are available to the trust to complete the development and sell or use the asset; and
- the trust can measure reliably the expenses attributable to the asset during development

Software

Software that is integral to the operating of hardware, for example, an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits over the following estimated lives:

Asset Category	Estimated life (in years)
Purchased computer software	2 to 8
Purchased Licenses & Trademarks	2 to 8
Internally generated IT	2 to 8

1.8 Donated, government grant and other grant funded assets

Government grants are grants from Government bodies other than income from CCG's or NHS Trusts for the provision of services. Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.9 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.10 Inventories

Inventories comprise mainly of drugs and consumable medical products which are held at the lower of cost or net realisable value. The cost formula is determined by using the latest cost price from suppliers. Due to the high turnover of inventories and the low value held, the Trust considers this method to be an appropriate basis of measurement. Net realisable value is the estimated selling price less estimated costs to achieve a sale.

1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

1.13 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into, in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.15.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the settlement date.

All other financial assets and liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

Financial assets are recognised on the Statement of Financial Position when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered.

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligations are discharged, cancelled or expire.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets"

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities"

Financial assets and financial liabilities at " fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure are financial assets or financial liabilities held for trading. A financial asset or liability is classified in this category of acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income

The Trust has the following categories of financial assets:

- Loans and receivables

Loans and receivables

The classification depends on the nature and purpose of the financial asset which is determined at the time of initial recognition. Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market and are included in current assets. The Trust's loans and receivables comprise of cash and cash equivalents, trade and other receivables, accrued income and prepayments.

Loans and receivables are recognised initially at fair value, net of transaction costs and are measured subsequently at amortised costs using the effective interest method. The effective interest rate is the rate that discounts exactly the estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within the 12months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other Finance Liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised costs using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial positon date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken on finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

The Trust's other financial liabilities comprise of DoH Loans, trade and other payables, accruals and provisions.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortisation cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value if the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

If in a subsequent period, the amount of the impairment loss decreased and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Income. This is to the extent that the carrying amount of the receivable, at the date of the impairment, is reversed does not exceed the amortised cost had the impairment not been recognised.

1.14 Financial Risks

Liquidity Risk

The Trust's net operating costs are mainly incurred under legally binding contracts with local CCG's, which are financed from resources voted annually by Parliament. Under Payment by Results the Trust is paid for activity on the basis on nationally set tariffs. For contracted activity the Trust is paid in 12 monthly instalments through the year which has in the latter part of the year included monthly payments for activity over contracted levels. This has reduced the liquidity risk. However the fact that the Trust does not have a working capital facility due to its current risk rating increases the Trusts liquidity risk. In addition the Trust recognises the issues around Going Concern which are outlined in note 1.1.

Interest–rate risk

All of the Trusts financial liabilities carry nil or fixed rates of interest, the Trust is not therefore exposed to significant interest rate risk.

Foreign currency risk

The Trust has no foreign currency income and negligible foreign currency expenditure.

Credit risk

The Trust operates primarily within the NHS Market and receives the majority of its income from other NHS organisations. There is therefore little risk that one party will fail to discharge its obligation with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payment by Results regime. The Trust does not hold any collateral as security.

1.15 Leases

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease, thereafter the asset is accounted for as an item of property, plant and equipment and the lease liability is de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income. Leases are assessed using IAS17 as a basis for qualitative and quantitative assessment.

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to the operating expenses on a straight-line basis over the term of the lease. Operating lease incentives are added to the lease rentals and charged to the operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component if it is considered to be material and the classification for each is assessed separately.

1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount at the statement of financial position date, for which it is probable that there will be a future outflow of cash or other resources and a reliable estimate of the expenditure can be made. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk adjusted cash flows are discounted using HM Treasury's discount rate. The rate for salary related provisions i.e. injury benefit provisions is 0.10% and long term provisions is -1.56% in real terms is applied.

Clinical Negligence

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS resolution, which in return, settles all clinical negligence claims. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the trust is disclosed at note 17 but is not recognised in the Trust's accounts.

Non-Clinical Negligence

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.17 Contingencies

Recognition

Contingent assets are assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control. They are not recognised as assets but are disclosed in note 20 unless the probability of a transfer of economic benefit is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the original NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as Public Dividend Capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash held with Government Banking Service excluding cash balances held in GBS account that relate to a short-term working capital facility and any (iii) PDC dividend balance receivable or payable.

The relevant net assets are adjusted for any liabilities or assets which the trust has as at the end of the accounting year, but may only have held for a short period close to the end of the accounting year.

In accordance with the requirements laid down by the Department of Health (DHSC) as issuer of PDC, the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.19 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Corporation Tax

The Trust does not foresee that it will have any material commercial activities on which a corporation tax liability will arise under the guidance issued by HM Revenue and Customs.

1.21 Foreign Exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into sterling at the exchange rate ruling on the dates of the transaction. Resulting exchange gains and losses are taken to the Statement of Comprehensive Income.

1.22 Third Party Assets

Assets belonging to third parties, such as money held on behalf of patients, are not recognised in the accounts since the Trust does not have any beneficial interest in them. However they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Finance Reporting Manual (FReM).

1.23 Losses and Special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks, with insurance premiums then being included as normal revenue expenditure.

However the information for losses and special payments is compiled directly from the losses and special payments register which reports on an accruals basis with the exception of provisions for future losses.

1.24 Accounting Standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted.

IFRS 9 Financial Instruments is a replacement of IAS 39 Financial Instruments: Recognition and Measurement. The impact of this is to provide a clearer definition for the recognition of financial assets and liabilities. The standard is allowing financial assets to be recognised at amortised cost if it meets both the business model test and the cash flow characteristics test; otherwise the assets are to be measured at fair value. It is expected that the Trust's Financial Assets will remain to be valued at fair value. The effective date is 2018/19 but it has not yet been adopted by the FReM.

IFRS 15 Revenue from Contracts and Customers

The main principle of this standard is that the entity recognises revenue to depict the transfer of promised goods and services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods and services. The standard is expected to be applied on an individual contract by contract basis but a portfolio approach is permitted where the impact on the financial statements will not be materially different from applying the Standard on an individual contract basis. It is not expected that this will have a material impact on the Trust. The effective date is 2018/19 but it has not yet been adopted by the FReM.

IFRS 16 Leases

The purpose of this new standard is to eliminate the classification of leases as either operating leases or finance leases for a lessee. Instead all leases will be treated in a similar way to finance leases applying IAS 17. Leases are 'capitalised' by recognising the present value of the lease payments and showing them either as lease assets (right-of-use assets) or together with property, plant and equipment. If lease payments are made over time, a company will also recognise a financial liability representing its obligation to make future lease payments. The trust has less than £0.4m of operating leases so it is not expected that this will have a material impact . The effective date is 2019/20 but it has not yet been adopted by the FReM.

FRS 17 Insurance Contracts

This standard establishes the principles for the recognition, measurement, presentation and disclosure of Insurance contracts within the scope of the Standard. The objective of IFRS 17 is to ensure that an entity provides relevant information that faithfully represents those contracts. This information gives a basis for users of financial statements to assess the effect that insurance contracts have on the entity's financial position, financial performance and cash flows. It is not expected that that this will have a material impact on the Trust. The effective date is 2021/22 but it has not yet been adopted by the FReM.

IFRIC 22 Foreign Currency Transactions and Advance Consideration the purpose of this standard is to clarify the accounting for transactions that include the receipt or payment of advance consideration in a foreign currency.

The Trust has minimal foreign currency transactions and therefore this will have an insignificant impact on the Trust. The effective date is 2018/19.

IFRIC 23 Uncertainty over Income Tax Treatments

The main principle of this standard is to clarify the accounting for uncertainties in income taxes. This is not expected to have a significant impact on the Trust. The effective date is 2019/20.

2. Operating Income

IFRS 8 requires the disclosure of results of significant operating segments, the Trust considers that it has only one operating segment, Healthcare.

2.1 Operating Income from Activities arising from Commissioner Requested Services

Under the terms of its Provider License, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested services and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that the commissioners believe would need to be protected in the event of provider failure.

The Trust's commissioner requested services is the total income from activities excluding private patient income and non–protected clinical income. Non protected income relates to overseas patients, the NHS Injury Scheme and other Non NHS bodies.

	2017/18 £000	2016/17 £000
Income from services designated (or grandfathered) as commissioner requested services	197,472	186,974
Income from services not designated as commissioner requested services	3,419	3,471
TOTAL	**200,891**	**190,445**

2.2 Operating Income from patient Care Activities (by nature)

	2017/18 £000	2016/17 £000
INCOME FROM ACTIVITIES		
Elective income	26,296	26,928
Non elective income	69,675	60,714
First outpatient income	16,557	14,772
Follow up outpatient income	21,748	23,682
A & E income	12,648	11,478
Other NHS clinical income	50,548	49,398
Private patient income	493	517
Other Non NHS clinical income	2,926	2,956
TOTAL INCOME FROM ACTIVITIES	**200,891**	**190,445**
Research and development	939	723
Education and training	7,628	5,859
Receipt of capital grants and donations	75	13
Non-patient care services to other bodies	1,271	1,534
Sustainability and Transformation Fund	10,374	10,547
Car parking	1,591	1,583
Staff Accommodation	1,051	874
Catering	739	980
Salary income	1,258	927
Other income	1,818	1,828
TOTAL OTHER OPERATING INCOME	**26,744**	**24,868**

* A £1.8 billion Sustainability and Transformation Fund (STF) was made available to NHS providers in 2017-18, linked to the achievement of financial controls and performance targets. NHS Improvement (NHSI), an arms length body of DHSC, has awarded STF income to Trusts which have achieved their assigned financial targets ('control totals') and specified clinical performance trajectories ('core' STF), exceeded their assigned 'control totals' through a £ for £ reward scheme ('incentive' STF), and to the extent that funds are available to NHSI, additional STF to Trusts meeting and/or exceeding their assigned 'control totals' ('bonus'STF)

The amount of core, incentive and bonus funding included above are £6.5m, £2.6m and £1m respectively and also includes £0.3m relating to the late notification of the 2016/17 final incentive allocation.

The Trust can confirm that there are no fees or charges raised under legislation, where the full cost exceeds £1 million, or the service is otherwise material in relation to the accounts.

2.3 Provision of goods and services for the purposes of health service

The Trust can confirm that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purpose. This is in accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

	2017/18 £000	2016/17 £000
income from the provision of goods and services for the purposes of the health service	197,472	186,974
income from the provision of goods and services for any other purpose	30,163	27,824
TOTAL	**227,635**	**215,313**

2.4 Private patient income

The Health and Social Care Act from the 1st October 2012 repealed the statutory limitation on private patient income in section 44 of the National Health Services Act 2006. The Trust earned 0.3% of total patient care income from private patients in both 2017/18 and 2016/17.

2.5 Operating Income from Patient Care Activities (by source)

	2017/18 £000	2016/17 £000
INCOME FROM PATIENT CARE ACTIVITIES RECEIVED FROM:		
CCGs and NHS England	196,780	186,306
Local authorities	1,797	1,625
Other NHS foundation trusts	633	657
NHS trusts	1	3
NHS other	58	78
Non-NHS: private patients	493	516
Non-NHS: overseas patients (chargeable to patient)	478	393
NHS injury scheme (was RTA)	634	807
Non NHS: other	17	60
TOTAL INCOME FROM ACTIVITIES	**200,891**	**190,445**
OF WHICH:		
Related to continuing operations	200,891	190,445

The responsibility for the commissioning of Healthcare services is from two main NHS Bodies, Clinical Commissioning Groups (CCG's) and NHS England. The major CCG for the Trust is Milton Keynes CCG and this accounts for 68% of the Trust's clinical income.

NHS England commissions nationally for a number of specialist services which includes HIV, Neonatology and Specialist Cancers and screening. The Trust received £26.3m 2017/18 in respect of these services (24.7m 2016/17). The Trust also received an additional £1m 2017/18 (£1.5m 2016/17) from the Cancer Drugs Fund.

2.6 Analysis of overseas visitors' income

	2017/18 £000	2016/17 £000
Income recognised this year	478	393
Cash payments received in-year	288	238
Amounts added to provision for impairment of receivables	67	68
Amounts written off in-year	123	87

3. Operating expenses

3.1 Operating expenses (by Type)

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	4,509	4,502
Purchase of healthcare from non-NHS and non-DH-SC bodies	4,421	3,420
Staff and executive directors costs	155,624	151,886
Remuneration of non-executive directors	116	115
Supplies and services - clinical (excluding drugs costs)	15,549	15,653
Supplies and services - general	3,611	3,382
Drug costs (drugs inventory consumed and pur-chase of non-inventory drugs)	19,605	17,468
Consultancy costs	350	1,600
Establishment	2,166	2,247
Premises	12,796	12,005
Transport (including patient travel)	553	417
Depreciation on property, plant and equipment	7,675	7,071
Amortisation on intangible assets	1,361	1,807
Net impairments	0	242
Increase/(decrease) in provision for impairment of receivables	(28)	640
Change in provisions discount rate(s)	25	133
Audit fees payable to the external auditor		
audit services- statutory audit	84	101
other auditor remuneration (external auditor only)	6	29
Internal audit costs	126	133
Clinical negligence	6,195	4,425
Legal fees	403	236
Insurance	113	126
Research and development - staff costs	987	799
Education and training - staff costs	2,712	1,556
Education and training - non-staff	890	596
Education and training - notional expenditure funded from apprenticeship fund	10	0
Rentals under operating leases	350	552
Car parking & security	35	49
Hospitality	18	27
Losses, ex gratia & special payments	91	165
Other services, eg external payroll	612	678
Other	(728)	421
TOTAL	**240,237**	**232,481**
OF WHICH		
Related to continuing operations	240,237	232,481

3.2 Arrangements containing an operating lease

	2017/18 £000	2016/17 £000
OPERATING LEASE EXPENSE		
Minimum lease payments	350	552
TOTAL	**350**	**552**

Operating lease includes rentals for a variety of medical equipment as well as photocopiers and lease cars.

	2017/18 £000	2016/17 £000
FUTURE MINIMUM LEASE PAYMENTS DUE:		
- not later than one year	143	331
- later than one year and not later than five years;	33	11
TOTAL	**176**	**342**

4.0 Staff costs

4.1 Staff costs

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	**120,462**	112,676
Social security costs	**13,121**	11,314
Apprenticeship levy	**616**	0
Employer's contributions to NHS pensions	**13,672**	12,604
Temporary staff	**11,452**	17,647
TOTAL GROSS STAFF COSTS	**159,323**	**154,241**

These costs exclude those for Non-Executive Directors' remuneration and benefits in kind.

4.2 Retirements due to ill-health

During 2017/18 there were 3 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £29k (£55k in 2016/17).

The cost of the ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

4.3 Employee Benefits

Employee benefits relate to payments made over and above salary costs. There were no employee benefits paid in the year or in the previous financial year.

4.4 Termination Benefits

There were no termination benefits during the year (Nil in 2016/17) and there were no non-compulsory departures agreed in 2017/18 or 2016/17.

4.5 Salary and pension entitlements of Directors

The aggregate amounts payable to directors were:

	2017/18 £000	2016/17 £000
Salary	1,286	1,213
Taxable benefits	0	0
Employer's pension contributions	127	137
TOTAL	**1,413**	**1,350**

4.6 Highest paid Director Analysis

Reporting Bodies are required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Milton Keynes University Hospital NHS Foundation Trust in the financial year 2017/18 was £175,000-£180,000 (2016/17 £175,000-£180,000). This was 5.89 times (2016/17 5.91 times) the median remuneration of the workforce which was £30,424 (2016/17 £30,333).

In 2017/18 and 2016/17 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £8,000 to £179,500 (2016/17 from £9,500 to £179,300).

Total remuneration includes salary, non-consolidated performance related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The median remuneration has been calculated using the full time equivalent annualised salary costs taken from the March payroll data, excluding the highest paid director but including agency and bank costs.

The Trust's highest paid Director was the Chief Executive and the remuneration costs that have been used in the calculation are the banded, full time equivalent annualised total remuneration costs. The previous year's highest paid director was the Chief Executive.

5.0 Better Payment Practice Code

5.1 Better Payment Practice Code - measure of compliance

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Total trade invoices paid in the year	77,456	127,402	83,645	124,114
Total trade invoices paid within target	70,386	118,528	74,298	110,326
Percentage of total trade invoices paid within target	91%	93%	89%	89%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's improvement is due to the agreed cash support the Trust received in year from the DoH which enabled the Trust to plan the payment of its creditors in a more timely manner. As a result there were no payments made in year in respect of late payment of invoices under the Late Payment of Commercial Interest Act 1998 (2016/17 £0).

6.0 Audit Fees

The Trust incurred statutory audit fees totalling £84,000, (£101,000 in 16/17) and £6k other auditor remuneration in 17/18, (£26,000 in 16/17). All the amounts include irrecoverable VAT. Other auditor remuneration is detailed below.

	2017/18 £000	2016/17 £000
OTHER AUDITOR REMUNERATION PAID TO THE EXTERNAL AUDITOR:		
All taxation advisory services	0	6
Other services	0	9
Audit related assurance services	6	14
TOTAL	**6**	**29**

7.0 Finance income and expense

7.1 Finance Income

	2017/18 £000	2016/17 £000
Interest on bank accounts	19	19
TOTAL	**19**	**19**

7.2 Finance Expenses

	2017/18 £000	2016/17 £000
INTEREST EXPENSE:		
Loans from the Department of Health	1,448	1,196
Finance leases	322	335
TOTAL INTEREST EXPENSE	**1,770**	**1,531**
Unwinding of Discount on Provisions	0	0
Other finance costs	0	133
TOTAL	**1,770**	**1,664**

7.3 Impairment of Assets (PPE)

	2017/18 £000	2016/17 £000
NET IMPAIRMENTS CHARGED TO OPERATING SURPLUS / DEFICIT RESULTING FROM:		
Unforeseen obsolescence	0	0
Changes in market price	0	242
TOTAL NET IMPAIRMENTS CHARGED TO OPERATING SURPLUS / DEFICIT	**0**	**242**
Impairments charged to the revaluation reserve	0	4,974
TOTAL NET IMPAIRMENTS	**0**	**5,216**

8. Intangible Assets

8.1 Intangible assets – 2016/17

	Software licences (Purchased) £000	Information technology (internally generated) £000	Development expenditure (internally generated) £000	Intangible assets under construction £000	Total £000
VALUATION/GROSS COST AT 1 APRIL 2017 - BROUGHT FORWARD	**4,418**	**6,719**	**468**	**2,065**	**13,670**
Additions	828	420	153	4,330	5,731
Reclassifications	0	134	0	(134)	0
Disposals / de-recognition	(9)	0	0	(15)	(24)
GROSS COST AT 31 MARCH 2018	**5,237**	**7,273**	**621**	**6,246**	**19,377**
AMORTISATION AT 1 APRIL 2017 - BROUGHT FORWARD	**3,238**	**4,319**	**389**	**0**	**7,946**
Provided during the year	567	734	60	0	1,361
Reclassifications	0	16	0	0	16
AMORTISATION AT 31 MARCH 2018	**3,805**	**5,069**	**449**	**0**	**9,323**
NET BOOK VALUE AT 31 MARCH 2018	**1,432**	2,204	**172**	**6,246**	**10,054**
NET BOOK VALUE AT 1 APRIL 2017	**1,180**	**2,400**	**79**	**2,065**	**5,724**

8.2 Intangible assets - 2016/17

	Software licences (Purchased) £000	Information technology (internally generated) £000	Development expenditure (internally generated) £000	Intangible assets under construction £000	Total £000
VALUATION/GROSS COST AT 1 APRIL 2016 - AS PREVIOUSLY STATED	**4,102**	**6,822**	**468**	**0**	**11,392**
Additions	316	2	0	2,065	2,383
Disposals / de-recognition	0	(105)	0	0	(105)
VALUATION/GROSS COST AT 31 MARCH 2017	**4,418**	**6,719**	**468**	**2,065**	**13,670**
AMORTISATION AT 1 APRIL 2015 - AS PREVIOUSLY STATED	**2,694**	**3,155**	**290**	**0**	**6,139**
Provided during the year	544	1,164	99	0	1,807
AMORTISATION AT 31 MARCH 2016	**3,238**	**4,319**	**389**	**0**	**7,946**
NET BOOK VALUE AT 31 MARCH 2017	**1,180**	**2,400**	**79**	**2,065**	**5,724**
NET BOOK VALUE AT 1 APRIL 2016	**1,408**	**3,667**	**178**	**0**	**5,253**

9.0 Property, Plant and Equipment

Property, plant and equipment as at 31st March 2018 is broken down in the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & POA	Plant & machinery	Transport equipment	IT	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
VALUATION/GROSS COST AT 1 APRIL 2017 - BROUGHT FORWARD	**23,631**	**122,766**	**855**	**110**	**24,439**	**26**	**8,268**	**402**	**180,497**
Additions	0	2,565	0	4,860	2,230	0	1,413	25	11,093
Revaluations	1,536	2,316	0	0	0	0	0	0	3,852
Reclassifications	0	61	0	(85)	20	0	4	0	0
Disposals / de-recognition	0	(19)	0	(24)	(63)	0	0	0	(106)
VALUATION/GROSS COST AT 31 MARCH 2018	**25,167**	**127,689**	**855**	**4,861**	**26,626**	**26**	**9,685**	**427**	**195,336**
ACCUMULATED DEPRECIATION AT 1 APRIL 2017 - BROUGHT FORWARD	**0**	**0**	**0**	**0**	**14,265**	**26**	**5,599**	**224**	**20,114**
Provided during the year	0	4,274	26	0	1,950	0	1,401	24	7,675
Revaluations	0	(4,266)	0	0	0	0	0	0	(4,266)
Reclassifications	0	6	0	0	(12)	0	(10)	0	(16)
Disposals/ de-recognition	0	0	0	0	(34)	0	0	0	(34)
ACCUMULATED DEPRECIATION AT 31 MARCH 2018	**0**	**14**	**26**	**0**	**16,169**	**26**	**6,990**	**248**	**23,473**
NET BOOK VALUE AT 31 MARCH 2018	**25,167**	**127,675**	**829**	**4,861**	**10,457**	**0**	**2,695**	**179**	**171,863**
NET BOOK VALUE AT 1 APRIL 2017	**23,631**	**122,766**	**855**	**110**	**10,174**	**0**	**2,669**	**178**	**160,383**

The disposals all relate to non-relevant assets ie they are not used in the delivery of Commissioner Requested Services.

VALUATION / GROSS AT 1 APRIL 2016 - BROUGHT FORWARD	**20,801**	**121,229**	**805**	**0**	**22,102**	**26**	**7,338**	**297**	**172,598**
Additions	0	3,557	0	110	2,595	0	939	105	7,306
Impairments	0	(5,207)	0	0	(9)	0	0	0	(5,216)
Revaluations	2,830	3,692	50	0	0	0	0	0	6,572
Disposals / de-recognition	0	(505)	0	0	(249)	0	(9)	0	(763)
VALUATION / GROSS AT 31 MARCH 2017	**23,631**	**122,766**	**855**	**110**	**24,439**	**26**	**8,268**	**402**	**180,497**
ACCUMULATED DEPRECIATION AT 1 APRIL 2016 - BROUGHT FORWARD	**0**	**2**	**(1)**	**0**	**12,480**	**26**	**4,476**	**207**	**17,190**
Provided during the year	0	4,037	24	0	1,870	0	1,123	17	7,071
Revaluations	0	(4,039)	(23)	0	0	0	0	0	(4,062)
Disposals/ de-recognition	0	0	0	0	(85)	0	0	0	(85)
ACCUMULATED DEPRECIATION AT 31 MARCH 2017	**0**	**0**	**0**	**0**	**14,265**	**26**	**5,599**	**224**	**20,114**
NET BOOK VALUE AT 31 MARCH 2017	**23,631**	**122,766**	**855**	**110**	**10,174**	**0**	**2,669**	**178**	**160,383**
NET BOOK VALUE AT 1 APRIL 2016	**20,801**	**121,227**	**806**	**0**	**9,622**	**0**	**2,862**	**90**	**155,408**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & POA	Plant & machinery	IT	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
NET BOOK VALUE AT 31 MARCH 2018								
Owned	24,847	106,619	249	4,861	9,819	2,695	179	149,269
Finance leased	320	5,297	580	0	479	0	0	6,676
Government granted	0	12,741	0	0	0	0	0	12,741
Donated	0	3,018	0	0	159	0	0	3,177
NBV TOTAL AT 31 MARCH 2018	**25,167**	**127,675**	**829**	**4,861**	**10,457**	**2,695**	**179**	**171,863**
NET BOOK VALUE AT 31 MARCH 2017								
Owned	23,331	102,216	(0)	110	9,349	2,669	178	137,853
Finance leased	300	5,140	855	0	619	0	0	6,914
Government granted	0	12,204	0	0	0	0	0	12,204
Donated	0	3,206	0	0	206	0	0	3,412
NBV TOTAL AT 31 MARCH 2017	**23,631**	**122,766**	**855**	**110**	**10,174**	**2,669**	**178**	**160,383**

9.1 Analysis of Plant, Property and Equipment

The Trust does not have any government granted or donated assets which have any restrictions or conditions imposed on them.

The Trust can disclose that there have been no disposals in year of land and building assets used for the delivery of commissioner requested services (CRS). In addition, as at 31 March 2018, the Trust had no land and buildings valued at open market value.

9.2 Capital commitments

There are four capital commitments, one (£2.2m) under Intangible capital expenditure relating to the E-Care project, and three (£0.5m) under PPE relating to the cancer centre, car park and north site infrastructure.

10. Investments Carrying Amount

Associate entities are those over which the Trust has the power to exercise a significant influence, but not control over the operating and financial management policy decisions. This is generally demonstrated by the Trust holding in excess of 20% but no more than 50% of the voting rights.

With effect from August 2009 the Trust has an associate investment in Milton Keynes Urgent Care Services, a community interest company (CIC) and holds an equity investment of 40% voting rights. The sum of the investment was £40. The entity is incorporated in the UK and accounted for at cost.

The Trust has chosen not to reflect any surplus or deficit from the associate in the Trust accounts as the Trust deems the impact of its share to not be material. In the event of any impact becoming material, the Trust will review the position and reflect this as appropriate.

11. Inventories

	Drugs	Consumables	Energy	Total
	£000	£000	£000	£000
As at 1 April 2017	**974**	**2,009**	**61**	**3,044**
Additions	19,789	17,877	44	**37,710**
Inventories consumed (recognised in expenses)	(19,605)	(17,841)	(51)	**(37,497)**
As at 31st March 2018	**1,158**	**2,045**	**54**	**3,257**
As at 1 April 2016	**1033**	**1,914**	**21**	**2,968**
Additions	17,409	17,339	62	**34,810**
Inventories consumed (recognised in expenses)	(17,468)	(17,244)	(22)	**(34,734)**
As at 31st March 2017	**974**	**2,009**	**61**	**3,044**

12. Trade and Other Receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	3,001	3,068
Accrued income	17,915	15,443
Provision for impaired receivables	(2,910)	(3,210)
Prepayments (non-PFI)	1,292	1,306
VAT receivable	1,220	1,109
Other receivables	2,705	2,070
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**23,223**	**19,786**
NON-CURRENT		
Other receivables	437	486
Provision for impaired receivables	(32)	(211)
TOTAL NON-CURRENT TRADE AND OTHER RECEIVABLES	**405**	**275**

NHS receivables are mainly considered recoverable because the majority of trade is with CCG's, as commissioners for NHS patient care services. CCG's are funded by the Government to purchase NHS patient care services, therefore no credit scoring of them is considered to be necessary. However, the Trust has recognised an impairment for receivables which relates to CCG income. Similarly other receivables with related parties are with other Government bodies, so no credit scoring is considered necessary.

Trade and Other Receivables includes £1.6m for the value of partially completed patient episodes as at 31st March 2018 (31st March 2017 £1.6m).

At the Statement of Financial Position date there were no material concentrations of risk, the maximum exposure to credit risk being the carrying values of trade receivables.

12.1 Provision For Impairment of Receivables

	2017 / 2018 £000
AT 1 APRIL AS PREVIOUSLY STATED	**3,421**
Increase in provision	2,425
Amounts utilised	(451)
Unused amounts reversed	(2,453)
AT 31 MARCH	**2,942**

The Bad debt provision decreased in 2017/18. The main reductions were due to compensation recovery cases and non NHS debtors.

12.2 Analysis For Impairment of receivables

	31 March 2018 Trade & other Receivables £000	31 March 2017 Trade & other Receivables £000
Ageing of impaired receivables		
0 - 30 days	14	35
30-60 days	7	26
60-90 days	10	0
90- 180 days	1,138	1,553
Over 180 days	1,773	1,807
TOTAL	**2,942**	**3,421**
AGEING OF NON-IMPAIRED RECEIVABLES PAST THEIR DUE DATE		
0 - 30 days	663	1,565
30-60 days	447	191
60-90 days	48	87
90- 180 days	357	615
Over 180 days	490	161
TOTAL	**2,005**	**2,619**

Impaired receivables, aged over 180 days in the main relates to payments from CCG's and payments from the Compensation Recovery Unit in relation to recovering costs arising through road traffic accidents. The irrecoverable debt provision has reduced to 22.84% from 22.94% as notified by the Department of Health.

13. Cash and cash Equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017 / 2018 £000	2016 / 2017 £000
At 1 April	**3,906**	**2,503**
Net change in year	(1,399)	1,403
At 31 March	**2,507**	**3,906**
BROKEN DOWN INTO		
Cash at commercial banks and in hand	73	53
Cash with the Government Banking service	2,434	3,853
TOTAL CASH AND CASH EQUIVALENTS AS IN SOFP	**2,507**	**3,906**
TOTAL CASH AND CASH EQUIVALENTS AS IN SOCF	**2,507**	**3,906**

Milton Keynes University Hospital NHS Foundation Trust held cash and cash equivalents which relate to monies held by the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

14. Liabilities

14.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	9,696	10,146
Capital payables	1,897	258
Accruals	10,479	10,534
Social security costs	1,922	1,645
Other taxes payable	1,683	1,441
PDC dividend payable	71	91
Accrued interest on loans	187	110
Other payables	2,398	1,999
Total current trade and other payables	**28,333**	**26,224**

14.2 Other Liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,637	1,625
TOTAL OTHER CURRENT LIABILITIES	**1,637**	**1,625**

15. Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health	32,154	32,153
Obligations under finance leases	144	166
Total current borrowings	**32,298**	**32,319**
Non-current		
Loans from the Department of Health	77,640	54,968
Obligations under finance leases	5,965	6,109
Obligations under PFI, LIFT or other service concession contracts	0	0
Total non-current borrowings	**83,605**	**61,077**

In year the Trust took out the following additional loan funding with the Department of Health.

- £18.8m in interim revenue loans,
- £4.8m in respect of capital funding.

The Loan profile along with the repayment details are show in the table below

Category of Loan	Amount of Original Loan	Balance Outstanding as at 31/3/18	Original Term	Agreed Extension	Interest Rate	Principal Repayment	Interest Payments
Interim Revenue Loan for 14/15	£25.3m	£25.3m	5 Years		1.50%	Nothing until in full Mar 2020	from Sep 2015 to Mar 2020
Interim Revenue Loan for 15/16	£31.2m	£31.2m	3 Years	1 Year	1.50%	Revised date: Nothing until in full Mar 2019	from Mar 2016 to Mar 2019
Revolving Revenue Working Capital Facility Conversion Loan 2016/17	£15.2m	£15.2m	3 Years		1.50%	Nothing until in full Jan 2020	from July 2017 to Jan 2020
Uncommitted Term Revenue Loan - Feb 2017	£3.2m	£3.2m	3 Years		1.50%	Nothing until in full Feb 2020	from Aug 2017 to Feb 2020
Uncommitted Term Revenue Loan - March 2017	£3.9m	£3.9m	3 Years		1.50%	Nothing until in full Mar 2020	from Sept 2017 to Mar 2020
Uncommitted Term Revenue Loan - May 2017	£2.3m	£2.3m	3 Years		1.50%	Nothing until in full May 2020	from Nov 2017 to May 2020
Uncommitted Term Revenue Loan - June 2017	£1.8m	£1.8m	3 Years		1.50%	Nothing until in full June 2020	from Dec 2017 to June 2020
Uncommitted Term Revenue Loan - July 2017	£2.1m	£2.1m	3 Years		1.50%	Nothing until in full July 2020	from Jan 2018 to July 2020
Uncommitted Term Revenue Loan - Sept 2017	£1.1m	£1.1m	3 Years		1.50%	Nothing until in full Sept 2020	from Mar 2018 to Sept 2020
Uncommitted Term Revenue Loan - Oct 2017	£1.0m	£1.0m	3 Years		1.50%	Nothing until in full Oct 2020	from Apr 2018 to Oct 2020
Uncommitted Term Revenue Loan - Nov 2017	£1.5m	£1.5m	3 Years		1.50%	Nothing until in full Nov 2020	from May 2018 to Nov 2020
Uncommitted Term Revenue Loan - Dec 2017	£1.9m	£1.9m	3 Years		1.50%	Nothing until in full Dec 2020	from June 2018 to Dec 2020
Uncommitted Term Revenue Loan - Jan 2018	£4.4m	£4.4m	3 Years		1.50%	Nothing until in full Jan 2021	from July 2018 to Jan 2021
Uncommitted Term Revenue Loan - Feb 2018	£2.6m	£2.6m	3 Years		1.50%	Nothing until in full Feb 2021	from Aug 2018 to Feb 2021
Total Capital Loans	**£97.5m**	**£97.5m**					
Capital IT Loan for 10/11	£4.0m	£0.9m	10 Years		4.00%	Aug 11 through to Feb 2020	Dec 2010 to Feb 2020
Interim Capital Loan for 15/16	£5.3m	£4.8m	17 Years		1.84%	Aug 16 through to Nov 2032	May 2016 to Nov 2032
Uncommitted Term Capital Loan 16/17	£1.9m	£1.7m	10 Years		0.61%	Sept 17 through to Mar 2027	from Sep 2017 to Mar 2027
Uncommitted Term Capital Loan 17/18	£4.8m	£4.8m	10 Years		1.23%	Aug 2020 through to Feb 2028	from Aug 2018 to Aug 2028
Total Capital Loans	**£16.0m**	**£12.2m**					
Total Loans	**£113.5m**	**£109.7m**					

16. Finance Lease obligations

The finance leases cover a number of different items of equipment, but the main items include the Trust's Accommodation Block, Beds and Multi-Function Devices (Printers).

The accommodation block has no option to extend or purchase in the current lease agreement. The Trust entered the 7 year extension period of the beds lease in 2016/17, with no option to purchase under the current lease terms. The Trust has the option to extend the lease for the Multi-Function Devices to the end of the useful economic life of the equipment, with no option to purchase under the current lease agreement.

Minimum Lease Payments

	31 March 2018	31 March 2017
	£000	£000
GROSS LEASE LIABILITIES	**10,591**	**11,080**
of which liabilities are due:		
- not later than one year;	451	488
- later than one year and not later than five years;	1,680	1,754
- later than five years.	8,460	8,838
	10,591	11,080
Finance charges allocated to future periods	(4,482)	(4,805)
NET LEASE LIABILITIES	**6,109**	**6,275**
of which payable:		
- not later than one year;	144	166
- later than one year and not later than five years;	592	611
- later than five years.	5,373	5,498
	6,109	**6,275**

17. Provisions

	Pensions (other staff)	Other * legal claims	Other **	Total
	£000	£000	£000	£000
At 1 April 2017	**44**	**3,046**	**890**	**3,980**
Change in the discount rate	5	0	20	**25**
Arising during the year	0	298	0	**298**
Utilised during the year	(7)	(217)	(34)	**(258)**
Reversed unused	0	(1,522)	0	**(1,522)**
At 31 March 2018	**42**	**1,605**	**876**	**2,523**
EXPECTED TIMING OF CASHFLOWS:				
Not later than one year	7	1,341	33	**1,381**
Later than one year and not later than five years	26	264	136	**426**
Later than five years	9	0	707	**716**
TOTAL	**42**	**1,605**	**876**	**2,523**

* Other legal claims includes contractual changes £0.4m, diagnostic records storage £0.9m, and various smaller provisions totalling £0.3m

**Other includes two injury benefit cases, one of which amounts to £0.5m.

	Pensions (other staff)	Other legal claims	Other *	Total
	£000	£000	£000	£000
At 1 April 2016	**44**	**2,001**	**798**	**2,843**
Change in the discount rate	7	0	126	**133**
Arising during the year	0	1,575	0	**1,575**
Utilised during the year	(7)	(55)	(34)	**(96)**
Reversed unused	0	(475)	0	**(475)**
At 1 April 2017	**44**	**3,046**	**890**	**3,980**
EXPECTED TIMING OF CASHFLOWS:				
Not later than one year	7	3,046	34	**3,087**
Later than one year and not later than five years	26	0	135	**161**
Later than five years	11	0	721	**732**
TOTAL	**44**	**3,046**	**890**	**3,980**

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event and it is probable that the Trust will be required to settle the obligation and a reliable estimate can be made of the obligation.

The above provision for pension costs relates to additional pension liabilities arising from early retirements. Unless due to ill-heath, these are not funded by the NHS Pension Scheme. As noted within note 1.5 the full amount of such liabilities is charged to the income and expenditure account at the time the Trust commits itself to the retirement.

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 0.1% in real terms.

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, and all clinical negligence claims are recognised in the accounts of the NHSLA, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is £74.5m (year ended 31 March 2017 £71.3m). No contingencies or provisions are in the accounts at 31 March 2018 in relation to these cases, even though the legal liability for them remains with the Trust.

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk-pooling schemes under which the Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

18. Revaluation Reserve

	Property, Plant & Equipment £000
Revaluation Reserve at 1 April 2017	**70,549**
Impairment losses property, plant and equipment	0
Revaluation gains property, plant and equipment	8,118
Other reserve movements	0
Revaluation Reserve at 31 March 2018	**78,667**
Revaluation Reserve at 1 April 2016	**64,889**
Impairment losses property, plant and equipment	(4,974)
Revaluation gains property, plant and equipment	10,634
Other reserve movements	0
Revaluation Reserve at 31 March 2017	**70,549**

19. Post Balance Sheet events

There are no post balance sheet events having a material effect of the accounts.

20. Contingent Liabilities

The Trust has reviewed its liabilities and it does not consider that it has any material contingent liabilities for the forthcoming financial year. The provisions that the Trust has made for liabilities and charges are disclosed in note 17 including provisions held by the NHSLA as at 31 March 2018 in respect of clinical negligence liabilities of the NHS Foundation Trust.

21. Related Party Transactions

The Trust is a body corporate established by the Secretary of State for Health. Government departments and their agencies are considered by HM Treasury as being related parties. During the year, the Trust has had a significant number of material transactions with other NHS bodies and in the ordinary course of its business with other Government departments and other central and local Government bodies. Most of these transactions have been with HMRC in respect of deductions and payment of PAYE, NHS Pensions Agency, Milton Keynes Council in respect of payment of rates and Milton Keynes CCG which is the Trust's local commissioner of NHS services. There are additional related parties of NHSI and the Milton Keynes Urgent Care Service, with which there have been no significant transactions in year.

	2017 / 18				2016 / 17			
	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due to related party	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due to related party
	£000	£000	£000	£000	£000	£000	£000	£000
Department of Health	5	0	0	0	(3)	0	90	0
NHS Bodies	1,599	3,745	329	1,343	1,225	3,483	203	1,275
Buckinghamshire Healthcare NHS Trust	1,567	108	843	113	1,414	18	285	27
Milton Keynes CCG	44	149,303	1,594	6,716	464	132,855	2,760	6,115
Bedfordshire CCG	0	12,934	95	541	0	12,917	64	420
NHS England	13	39,753	694	7,426	13	36,779	2,223	7,431
NHS Aylesbury Vale CCG	0	9,502	52	1,776	0	8,439	12	489
NHS Nene CCG	0	3,532	12	136	0	3,332	11	100
Bedford Hospital NHS Trust	213	163	95	139	206	167	62	49
Oxford University Hospital NHS FT	1,465	1,854	696	274	1,047	1,769	196	335
NHS Resolution	6,305	0	0	0	4,538	0	0	0
Central and North West London NHS Foundation Trust	428	1,245	58	316	348	1,107	22	275
Luton & Dunstable University Hospital NHS Foundation Trust	678	322	287	331	779	0	340	0
Health Education England	15	4,970	6	0	25	4,831	0	0
OTHER								
Other WGA Bodies	37	58	0	37	11,334	78	0	1,064
NHS Blood and Transplant (outside DH Group)	1,021	0-	89	0	1,027	10	49	0
Local Authorities	21	3,199	0	0	108	2,465	0	0
HMRC	13,737	0	3,605	1,220	0	0	3,086	1,109
NHS Pensions	13,672	0	1,960	0	12,604	0	1,761	0
MK Charity	0	333	0	25		191		100
TOTAL	**40,820**	**221,021**	**10,415**	**20,398**	**35,129**	**208,431**	**11,164**	**18,789**

The key management personnel of the Trust are all directors of the Trust. Their remuneration is disclosed in note 4.5. During the year none of the members of the key management personnel, or parties related to them, have undertaken any material transactions with the Trust.

22. Financial Instruments

	31 March 2018 £000	31 March 2017 £000
Cash	2,507	3,906
TOTAL CAPITAL	**2,507**	**3,906**
Total Equity	2,507	3,906
Borrowings	115,903	93,396
OVERALL FINANCING	**118,410**	**97,302**
CAPITAL TO OVERALL FINANCING RATIO	**2%**	**4%**

Capital Risk Management

The Trust's capital management objectives are:

- to ensure the Trust's ability to continue as a going concern; and
- to provide an adequate return to reinvest in healthcare services by providing healthcare services commensurately with the level of risk of receiving income for those services provided.

The Trust monitors capital on the basis of the carrying amount of Public Dividend Capital less cash presented on the face of the balance sheet.

The Trust sets the amount of capital in proportion to its overall financing structure, i.e. equity and financial liabilities. The Trust manages the capital structure and makes adjustments to it in light of changes in economic conditions and the risk characteristics of the underlying assets.

Interest Rate Risk

The Trust is not exposed to significant interest rate risk as the Borrowings are all at a fixed rate of interest.

Liquidity Risk

The Trust's net operating income is mainly incurred under legally binding contracts with the local CCG's, which are financed from resources voted annually by Parliament. Under Payment by Results, the Trust is paid for the activity on the basis of nationally set tariffs. For contracted activity, the Trust is paid in 12 monthly instalments throughout the year, which significantly reduces the liquidity risk. Performance in excess of contracted levels up to the end of September 2017 has been agreed and paid for by Milton Keynes CCG at PbR rates. However, the Trust is looking for further support to its working capital during 2017/18 from the DoH.

22.1 Financial assets by category

	31 March 2018 Loans & Receivables £000	31 March 2017 Loans & Receivables £000
Trade and other receivables excluding non-financial assets	21,117	17,646
Cash and cash equivalents at bank and in hand	2,507	3,906
Total at 31 March	**23,624**	**21,552**

22.2 Financial liabilities by category

	31 March 2018 Other financial liabilities £000	31 March 20167 Other financial liabilities £000
Borrowings excluding finance lease	109,794	87,121
Obligations under finance leases	6,109	6,275
Trade and other payables excluding non-financial liabilities	24,657	26,224
Provisions under contract	1,605	2,096
Total at 31 March	**142,165**	**121,716**

22.3 Fair values of financial assets

	31 March 2018 £000	31 March 2017 £000
Non-current trade and other receivables excluding non-financial assets	405	275
Total	**405**	**275**

Current Financial Assets Book and Fair values are assumed to be the same values.

22.4 Fair values of financial liabilities

Current and Non-Current Financial Liabilities Book and Fair values are assumed to be the same values.

22.5 Maturity of Financial Liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	57,436	60,639
In more than one year but not more than two years	48,644	1,052
In more than two years but not more than five years	19,412	48,035
In more than five years	16,673	11,990
TOTAL	**142,165**	**121,716**

23 Third Party assets

The Trust held no third party assets at the end of financial year 2017/18.

24. Losses and special payments

There were 245 cases at 31 March 2017 of losses and special payments totalling £165,000 approved during the year (182 cases to 31 March 2016 totalling £178,000) These payments are the cash payments made in the year and are calculated on an accruals basis. There were no compensation payments recovered during the year. Details of the payments are shown in the table on the following page.

	31 March 2018		31 March 2017	
	Total number of cases	Value £000	Total number of cases	Value £000
1. LOSSES OF CASH DUE TO:				
a. theft, fraud etc	0	0	0	0
b. overpayment of salaries etc.	19	23	25	12
2. FRUITLESS PAYMENTS AND CONSTRUCTIVE LOSSES	0	0	0	0
3. BAD DEBTS AND CLAIMS ABANDONED IN RELATION TO:				
a. private patients	5	1	13	3
b. overseas visitors	49	123	81	87
c. other	56	1	82	11
4. DAMAGE TO BUILDINGS, PROPERTY ETC. DUE TO:				
b. stores losses	12	23	16	40
TOTAL LOSSES	**141**	**171**	**217**	**153**
SPECIAL PAYMENTS				
5. COMPENSATION UNDER LEGAL OBLIGATION	0	0	0	0
6. EXTRA CONTRACTUAL TO CONTRACTORS	0	0	0	0
7. EX GRATIA PAYMENTS IN RESPECT OF:				
a. loss of personal effects	18	5	18	10
b. clinical negligence with advice	0	0	0	0
d. other negligence and injury	0	2	0	0
g. other	10	0	10	2
TOTAL SPECIAL PAYMENTS	**25**	**7**	**35**	**111**
TOTAL LOSSES AND SPECIAL PAYMENTS	**166**	**178**	**182**	**178**

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