TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Milton Keynes University Hospital NHS Foundation Trust Annual Quality Account 2024-25

Milton Keynes University Hospital NHS Foundation Trust 2024/25 Quality Account

PART 1: THE QUALITY ACCOUNT

1.1 Introduction

Milton Keynes University Hospital NHS Foundation Trust (referred to as 'MKUH' or 'the Trust') is a district general hospital providing a comprehensive range of general medical and surgical services, including an Emergency Department (ED), Maternity, and Paediatrics. As the population of Milton Keynes and its surrounding areas continues to grow rapidly, we are expanding and enhancing our facilities to meet increasing demand and improve access to care for all our communities.

In addition to providing core acute services, the Trust has expanded its portfolio of specialist services. This includes the new **Radiotherapy Centre**, opened in January 2025 which significantly enhances cancer care by offering advanced treatment options closer to home. Other specialist services include neonatology, specialist surgical care, and an expanded range of diagnostic services, supported by the newly operational **Community Diagnostic Centre** at Whitehouse Health Centre. Construction also began in January 2025 on **Oak Wards**, a new ward block which will feature two 24-bed wards across two floors, providing a significant increase in capacity for medical patients. And that month, the final green light was given by the Government for the Trust's new **Women and Children's Centre**, expected to be complete by 2030.

Our mission remains to deliver high-quality care, ensuring patients receive the right treatment, in the right place, at the right time. The Trust's strategic objectives continue to focus on delivering safe, effective, and patient-centred care. Our three core objectives are:

1. **Improving patient safety**
2. **Enhancing patient experience**
3. **Strengthening clinical effectiveness**

To maintain high-quality standards, we have a robust framework for monitoring performance against both local and national benchmarks. This framework ensures that we identify areas for improvement early, allowing us to implement timely interventions and continuously improve patient care.

We are proud of our dedicated staff, whose professionalism and compassion underpin the care we provide every day. Our relationships with local stakeholders, including patients, carers, governors, Healthwatch Milton Keynes, and system partners, remain central to our strategy for continuous improvement. Our governors actively engage with the community, offering scrutiny and support for Trust activities and participating in forums that promote patient and public involvement.

Throughout 2024/25, we continued our close collaboration with the **Milton Keynes Council Health and Adult Care Scrutiny Committee** and the **Health and Wellbeing Board**. These partnerships have played a vital role in shaping the Trust's approach to quality and patient safety, not only within MKUH but across the broader Milton Keynes health and care system.

This **Quality Account** is our annual public report detailing how we continue to improve the quality of the services we provide. It outlines the Trust's progress against previously set quality priorities and highlights key achievements from the past year.

The primary aims of this report are to:

- Enable patients and carers to make informed decisions about their healthcare providers
- Provide transparency for the public to hold us accountable for the quality of care we deliver
- Offer an assessment tool for NHS Boards to evaluate service improvements and set priorities for the year ahead

For the coming year (2025/26), the Trust has identified at least three **quality priorities**, which are detailed in Part 2 of this Quality Account. These priorities have been selected using the following criteria:

- A comprehensive review of service quality and performance data
- Alignment with national and local health priorities and indicators
- Focus on the three core domains of quality: **patient safety**, **clinical effectiveness**, and **patient experience**

The Trust will monitor, measure, and report on progress toward these priorities through a structured framework of performance reviews and stakeholder engagement. This Quality Account offers a clear evaluation of how well MKUH has performed across a range of quality measures throughout 2024/25 and sets out our goals for the year ahead as we continue to improve and innovate in response to the evolving needs of our community.

1.2 Statement on Quality from the Chief Executive

I am delighted to introduce this year's Quality Account for Milton Keynes University Hospital (MKUH) NHS Foundation Trust.

This report reflects on our ongoing efforts to improve the quality of care provided to our patients throughout 2024/25 and outlines the opportunities we have identified for further improvement in the coming year and beyond. Our unwavering focus remains on delivering excellent care for every patient, every time.

Each year, we reaffirm our three core quality objectives:

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

These objectives underpin everything we do at MKUH, and we continue to monitor our performance rigorously through national, internal, and peer-benchmarked indicators. Metrics such as infection rates, pressure ulcers, serious incidents, and mortality figures are regularly published at our Trust Board meetings, ensuring transparency and accountability.

In October 2024, the results from the 2023 Care Quality Commission (CQC) Adult In-patient Survey were published, with feedback from over 500 patients who received care at MKUH. The results highlighted continued improvements across several key areas:

- The quality of food received an improved score of **7.5** (up from **7.3** the previous year).
- Dietary alternatives received a rating of **8.6**, reflecting our commitment to patient choice and inclusivity.
- Patients rated their confidence in the care provided by our doctors and nurses highly, with scores of **9.1** and **9.0** respectively.

However, we also acknowledge areas where improvements are needed. Concerns around noise at night, sleep disruptions due to lighting, and family involvement in discharge discussions remain key priorities. To address these, we have:

- Expanded the ‘Night-Mode’ initiative to further reduce noise levels during rest hours.
- Introduced hospital-wide motion-sensor LED lighting for a softer, more restful environment.
- Enhanced our family engagement approach by establishing dedicated liaison teams to keep families informed about patient care and discharge planning.

We also welcome the Care Quality Commission’s recognition of the improvements made to our urgent and emergency services, which are now rated as good, following an inspection in April 2024. The CQC also raised the services’ ratings for being safe and well-led from requires improvement to good, and again rated the service as good for being effective, caring, and responsive. As a result, the Trust remained rated as good overall, and for effective, caring, responsive, and well-led. Whilst we were pleased that the services concerned were now recognised as good, we realise there is still much work to do now and moving forward, and we are confident our dedicated and compassionate staff will continue to rise to the challenges that are likely to come their way in the future.

When it came to the Trust’s Maternity Survey results, however, in November 2024 it was shown that feedback from 117 women revealed a number of areas as needing improvement, with the CQC describing those areas as ‘significantly worse’ than the national average. Whilst these results were disappointing, the Trust at that time had already embarked on a wide-ranging action plan to improve women’s experience of labour, birth and postnatal care. Improvements being made included the appointment of a new labour ward matron, and providing senior oversight of all patient care on the ward to ensure women in labour receive the care and support they need. The maternity

team was also restructured, with additional midwives now on the labour ward, antenatal ward and postnatal ward to support women and their families before, during and after birth. As part of a broader postnatal improvement plan, an additional ward is now permanently open, providing seven extra beds for women and their babies. The postnatal improvement plan, developed with our local Maternity Voices Partnership groups, also saw the introduction of bedside handovers to ensure that women and their families are involved in the planning of their care. We will share our improvement plans with our local communities and ensure that they are involved in making services better for them now and in the future.

Another new initiative to highlight is the My Thank You scheme, allowing patients and visitors at MKUH to send personal messages of gratitude to members of staff who have made their day. With just a few clicks on a PC or taps on a mobile phone, hospital visitors can send heartfelt messages to any staff member, specific team or department, or volunteer, brightening the day of those who work tirelessly to serve the community's healthcare needs. I for one am incredibly proud of our dedicated staff, whose passion and commitment drive our mission to provide high-quality care for all.

With Milton Keynes continuing to be one of the fastest-growing cities in the UK, expanding and improving our services is essential to meet the needs of our diverse and growing population. Despite the challenges this represents, I am excited about what the future holds for MKUH. We are committed to developing our hospital to meet the future healthcare needs of our community, with significant work already taking place.

In October 2024, we opened our second Community Diagnostic Centre at Lloyds Court in central Milton Keynes, allowing more patients to access diagnostic services easily in the community. In January this year, in partnership with Oxford University Hospital, we opened the Radiotherapy Centre at MKUH, bringing radiotherapy treatment closer to home for many patients in Milton Keynes. Further to this, we are pleased to be building a new 48-bed, two-storey ward block known as Oak Wards, which is currently under construction and will be completed early next year, providing additional medical bed capacity to our site.

As part of our hospital's extensive expansion plans, we are delighted that the Secretary of State for Health and Social Care announced in January that plans will go ahead to deliver a new hospital facility at MKUH, under the Government's New Hospital Programme. The new hospital is the largest infrastructure project since the hospital was opened in 1984. It includes a number of enabling projects to prepare our site, including a new multi-storey car park and Imaging Centre, which are currently under construction. The new hospital building will become the new home for women's and children's services and will also provide additional elective surgical bed capacity. Its construction is expected to take place between 2025 and 2030.

Alongside these efforts, we will also embrace the opportunities that digital enhancements can bring to transform the care we provide for our patients, ensuring that we continue to meet the needs of our community now and in the years to come. We are committed to supporting our staff and innovating wherever we can to best serve our patients and communities.

Thank you for your continued support as we strive to deliver outstanding healthcare for all.

Joe Harrison
Chief Executive
26 June 2025

1.3 Statement of Assurance

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

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

During the year, we have continued to be actively engaged with place-based and system health and care partners, including 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.

Joe Harrison
Chief Executive Officer
26 June 2025

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENT OF ASSURANCE FROM THE BOARD

2.1 Priorities for Improvement in 2025/26

This section of the Quality Account describes the areas we have identified for improvement in 2025/26. In March 2025, these priorities were shared with and agreed by our Quality and Clinical Risk Committee followed by an approval by the Council of Governors – a body made up of elected members of staff, members of the public and nominated stakeholder representatives.

The plan is to realign some of the 2024/25 priorities, continuing two aspects for another year. Priority one which is continuing for the third year, aligns with the Trust's operational priorities and wider national ambitions. Priority two is rolled over for a second year to enable us to consolidate our achievements from last year. The third priority is a safety and effectiveness priority based on current safety and clinical effectiveness data.

The first priority: Improving the management of the deteriorating patients including sepsis (continued priority from previous years)

The second priority: Reducing the number of complaints citing poor communication (continuing from last year).

The third priority: Reduction in violence and abuse

- **Priority 1: Improving the management of the deteriorating patient including sepsis**

Sepsis remains a critical area for continuous improvement to ensure coordinated and focused efforts on its identification, treatment, and management. The focused work in the Emergency Department is being expanded to other admitting wards and departments, including maternity. This program continuously addresses issues highlighted in previous Coronial recommendations and involves patients and families to understand their experiences and the impact of a sepsis diagnosis. We aim to maintain the momentum built with the sepsis quality improvement programs, especially with the introduction of Martha's Rule, supporting timely interventions for deteriorating patients.

What is our past performance in this area?

In 2024/25, we established an improvement program to examine how patients at risk of sepsis are identified and the care pathway and clinical interventions they receive. This program continues to enable the cycle of improvement through national and local audits, allowing the Trust to understand the impact of interventions and identify areas for further improvement.

How will we monitor and measure our performance in 2025/26?

Sepsis and deteriorating patients will be monitored through a comprehensive audit and ward accreditation program. A standardized audit tool has been developed to facilitate monthly data collection and analysis. The findings are regularly reviewed and shared

with healthcare teams to formulate action plans and utilize continuous improvement to refine practices. Senior nursing leadership actively participates in regular compliance reviews to sustain improvements and enhance patient outcomes. A sample audit tool is included below in Appendix 1.

In addition to monitoring compliance with the Royal College of Emergency Medicine standards in the Emergency Department, there is continuous local audit monitoring of the treatment for patients requiring antibiotics in accordance with updated NICE guidelines. An example audit tool is shown below in Appendix 2.

During 2025-26, we will continue to work towards achieving the following metrics:

- 90% of patients meeting red sepsis criteria receive antimicrobials within 1 hour.
- 90% of patients meeting amber sepsis criteria receive antimicrobials within 3 hours.
- 90% of patients receive antimicrobials within 30 minutes of prescription.

We are continuously refining the RADAR (patient incident record platform) incident categories to better categorize sepsis incidents, ensuring ease of recording and more insightful analysis. Additionally, we are enhancing our patient management system to automatically identify patients who require sepsis screening. This is one of the key improvements outlined in the Sepsis Quality Improvement Group workplan.

Reporting Progress

Progress will be reported quarterly to the Quality and Clinical Risk Committee (a sub-Committee of the Trust Board), the Quality Learning and Improvement Board, and the Trust Executive Committee in 2025/26. Routine updates will also be provided to the Council of Governors as part of the Trust's commitment to accountability.

Figure 1: A sample sepsis audit tool

Question
Is there documentary evidence that the SBAR tool was used to document the escalation of care for the patient on the amber alert?
If the patient has triggered a red alert were the patient's physiological observations assessed continuously and recorded every 15 minutes?
Is there documentary evidence that the SBAR tool was used to document the escalation of care (Red Alert)?
Has the sepsis screening tool been immediately completed if the NEWS2 score is five or more(Red Alert?
If the patient has triggered an amber alert, has the patient's physiological observations been assessed, recorded, and a NEWS2 score accurately calculated to a minimum o
Has the sepsis screening tool been immediately completed if the NEWS2 score is five or more (Red Alert)?
Is there documentary evidence that the patient's condition was immediately escalated to the Rapid Response team(Red Alert)?
Has the patient on amber alert been urgently assessed by a clinician within an hour (Amber Alert)?
Is there documentary evidence that the patient had an emergency assessment by the clinician within an hour (Red Alert)?
Have blood cultures and blood been sent within 1 hour of identifying sepsis?
Is there documentary evidence that the patient's condition was immediately escalated to the medical team at a minimum of specialist registrar level or above (Red Alert)?
Is there documentary evidence that the medical team have been immediately informed about the patient on amber alert?
Is there documented evidence of increased monitoring and recording of vital signs in response to any deterioration in the patient's condition?
Is there documentary evidence that the nursing care provided to manage the deterioration in the patient's condition has been recorded (Red Alert)?
In the event of a deterioration, is there documented evidence of escalation of care as per NEWS2 Escalation Protocol?
Is there documentary evidence that the nursing care provided to manage the deterioration in the patient's condition has been recorded(for patient on amber alert)?
Is there documentary evidence that the registered nurse reviewed and assessed the patient on the amber alert?
Has the sepsis care bundle/care plan been commenced?
Is there documentary evidence that the registered nurse immediately reviewed and assessed the patient on red alert?
If the patient has triggered a green alert, has the patient's physiological observations been assessed, recorded, and a NEWS2 score accurately calculated every 4 to 6 hours
Have IV fluids been administered within 1 hour?
Is there documentary evidence that the registered nurse has reviewed and assessed the patient(Green Alert)?
Have the patient's physiological observations been reassessed and recorded using NEWS2 at the appropriate frequency for their clinical condition?
Are conversations relating to decisions about resuscitation and escalation of treatment clearly and appropriately documented?
Have antibiotics been administered within 1 hour?
Has Oxygen been administered within 1 hour of identifying sepsis?
Is the blood glucose monitoring kit fully stocked, and are all items in it in date?
Has the patient's baseline physiological observations been assessed and recorded within 1 hour of admission/transfer , and the NEWS score is accurately calculated ?
Resuscitation equipment is clean, checked and documented in accordance with organisational policy for the past 7 days.
Is the hypoglycaemia box easily accessible, and are staff aware of where it is kept?

Figure 2: Emergency department audit for timely antibiotics

Red Criteria
Total number of patients audited
Not Sepsis
Sepsis
Average time to antimicrobials
Received antimicrobials within 60 minutes
Received antimicrobials within 30 minutes of prescription
Received gentamicin (where appropriate)
Average length of stay
All cause mortality
Blood cultures
Total number of patients who had blood cultures obtained

Amber Criteria
Total number of patients audited
Not Sepsis
Sepsis
Average time to antimicrobials
Received antimicrobials within 180 minutes
Received antimicrobials within 30 minutes of prescription
Received gentamicin (where appropriate)
Average length of stay
All cause mortality
Blood cultures
Total number of patients who had blood cultures obtained

- **Priority 2: Reducing the number of complaints citing poor communication.**

Communication is commonly cited as a problem in complaints received by the Trust as well as being identified as a thematic issue in patient surveys. Communication is a broad category, encompassing pre-hospital communication (appointment letters/ digital communications, telephone systems); in-hospital care (outpatient and inpatient) and care on and after discharge. Poor communication can result in complaints and a poor patient experience. The Trust is keen to make this a focus for improvement work in 2024/25 to improve patient experience overall and reduce the number of complaints where communication is the main cause of poor experience.

What was our past performance in this area?

During 2025/26, the Trust received 1220 complaints in total, this includes complaints dealt with through the formal complaints process and those dealt with informally through the PALS process. Of those complaints, 282 specifically cited communication as being the main cause for raising a complaint, although most complaints incorporate an element of communication within other issues that are raised.

The communication issues raised in those complaints where communication was the main issue are detailed below:

Breaking bad news	2
Communication failure between teams	4

Communication failure with GP	2
Communication failure with other secondary provider	1
Communication failure with patient	117
Communication failure with relatives/carers	40
Communication failure within teams	3
Conflicting information	14
Discharge plans - Lack of communication with patient/family	9
Inadequate information provided	44
Incorrect information given	10
Interpreting issues	2
Method / Style of communication	13
Patient not listened to	21

There were 37 formal complaints and 245 informal complaints where communication was the main issue.

The communication issues arise across the Trust, however, specifically the Emergency Department, cardiology, central booking team, gynaecology consultants, imaging, neurology, urology, Wards 1 and 3, orthopaedics and haematology and oncology are receiving the most complaints in this area.

How did we monitor and measure our performance in 2024/25?

- Monthly analysis of complaint themes Trust wide
- Divisional deep dives in the Patient and Family Experience Board
- Patient Experience Platform analytics
- Ward accreditation metrics

How did we report our progress against achieving this priority?

Quarterly reports were submitted to the Quality and Clinical Risk Committee (sub-Committee of the Board), Patient and Family Experience Board and the Trust Executive Committee.

How will we monitor and measure our performance in 2025/26?

- Monthly analysis of complaint themes Trust wide
- Patient Experience Platform analytics
- Dedicated improvement programme with audit information
- Ward accreditation metrics

How will we report our progress against achieving this priority?

A quarterly report will be submitted to the Quality and Clinical Risk Committee (sub-Committee of the Board), Patient and Family Experience Board and the Trust Executive Committee.

❖ Priority 3: Reduction in Violence and Abuse

Everyone—whether staff, patients, or visitors—has the right to feel safe while under the care of Milton Keynes University Hospital (MKUH). The Trust has both a legal and moral responsibility to uphold this safety by implementing proactive measures to protect all individuals from harm.

The patient demographic is evolving, particularly in the aftermath of the COVID-19 pandemic. We are seeing a notable increase in patients presenting with cognitive impairments and mental health conditions, increasing number of older adults in Milton Keynes living with conditions such as dementia.

These changing needs place significant pressure on our staff, who consistently deliver high-quality care while managing the complexities of ensuring safety—for themselves, their colleagues, and their patients. This environment not only increases the risk of staff being subjected to violence and abuse, but also creates potential for patient-on-patient incidents, either directly or as witnessed events.

No one should come to work—or seek care—in an unsafe environment. That is why the Trust is committed to implementing robust strategies that not only help prevent incidents but also provide support before, during, and after any such events.

We acknowledge the rising trend of violence and abuse within the organisation. In response, the Trust has begun developing and implementing a series of protective, preventative, and supportive measures to address this issue.

The 2024 NHS Staff Survey results reinforce the reality of staff experiencing violence and abuse from patients, service users, and the public. By taking meaningful action to reduce the frequency and impact of these incidents, the Trust aims to create a safer and more supportive working environment. These efforts are not only essential to staff wellbeing but also contribute to improved patient care, reduced absenteeism, and stronger staff recruitment and retention.

As part of proactive measurements strategies, wards/departments are required to complete risk assessments as required by health and safety legislation, taking into account the types and numbers of incidents occurring or the potential foreseeable risks posed. These inform continuous improvement and risk mitigation.

When a trend or recurring theme is identified, the Health and Safety Team escalates concerns to the Executive Team, the Executive Lead for Health and Safety, and the

Chief Nurse or Deputy Chief Nurse as appropriate. The team also provides ongoing support to wards, departments, and individual staff members who have experienced incidents of violence or abuse and staff are encouraged to report incidents to the police. This is done in close collaboration with the Security Team and the Patient Safety Team to ensure a coordinated and effective response.

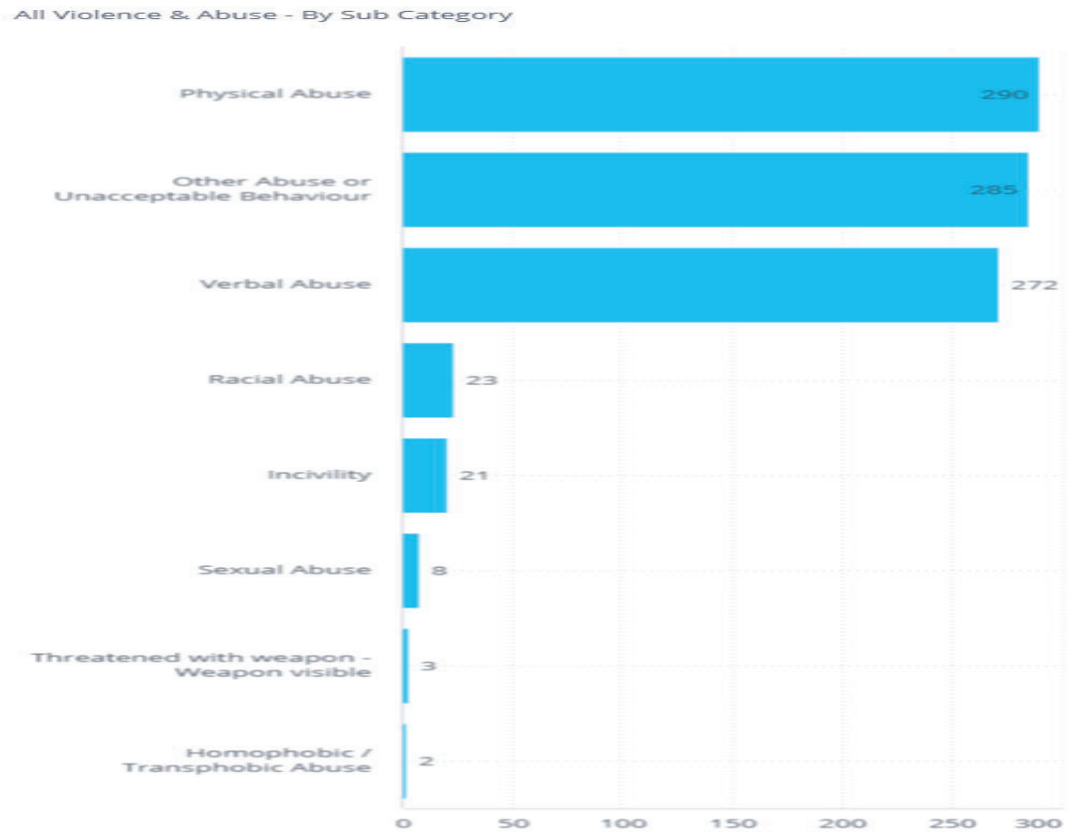
It is recognised that in some cases, repeated incidents may be linked to a single patient—particularly those who are long-term inpatients. As such, not all incidents represent isolated events, and the cumulative impact on staff and ward environments must be taken into account.

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

During the period of 1st April 2024 to 31 March 2025 a total of 865 reports of violence, abuse and challenging behaviour were recorded onto the RADAR incident reporting system.

78% (674) of incidents reported were perpetrated by patients/visitors/third parties/relatives against staff. Of that total 46% of individuals were deemed to have cognitive impairment/dementia diagnosis. This number may not be accurate and is dependent upon the reporter identifying that diagnosis at the time of submitting the incident form.

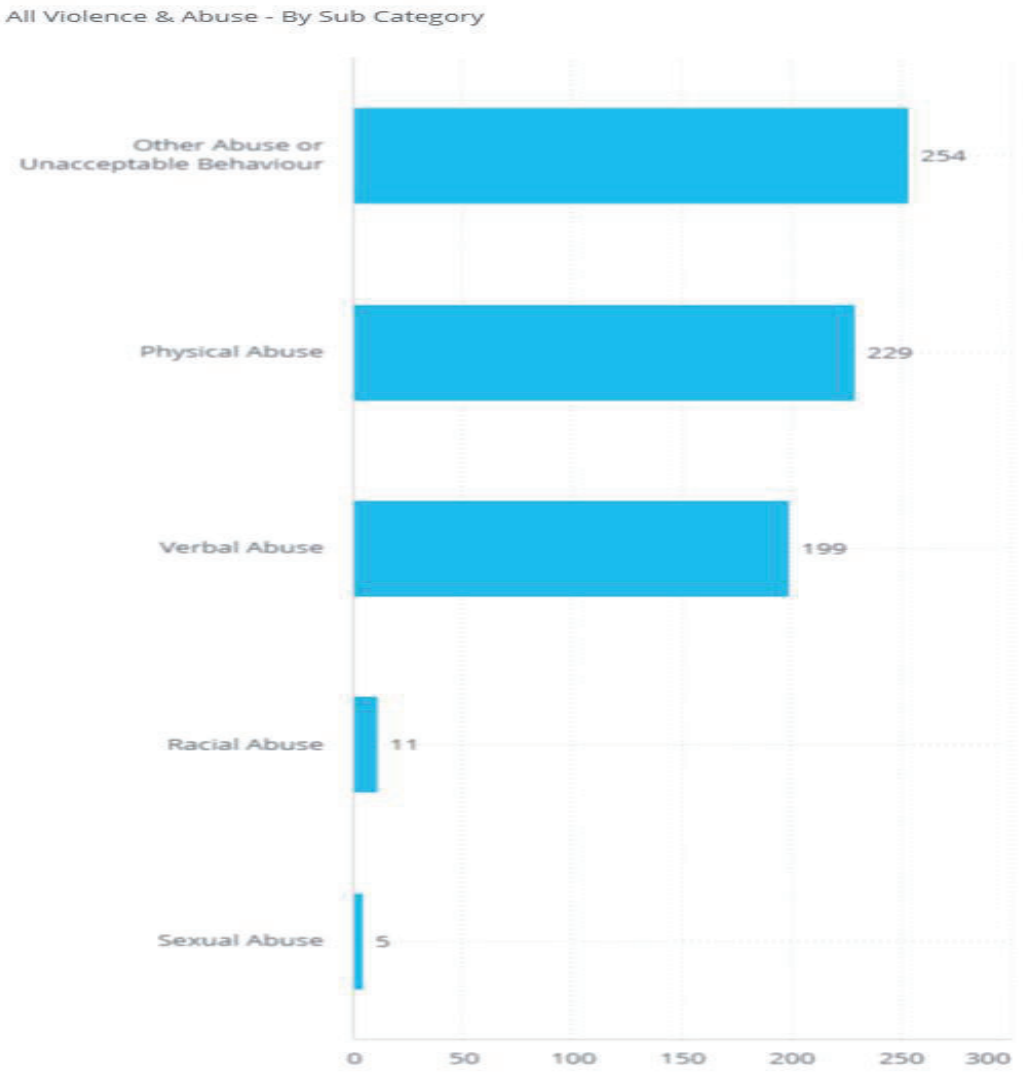
The below table identifies the sub categories of incidents reported.



One incident was reported to the Health and Safety Executive under RIDDOR due to the staff member being injured and subsequently absent from work as a result of injuries sustained in the assault.

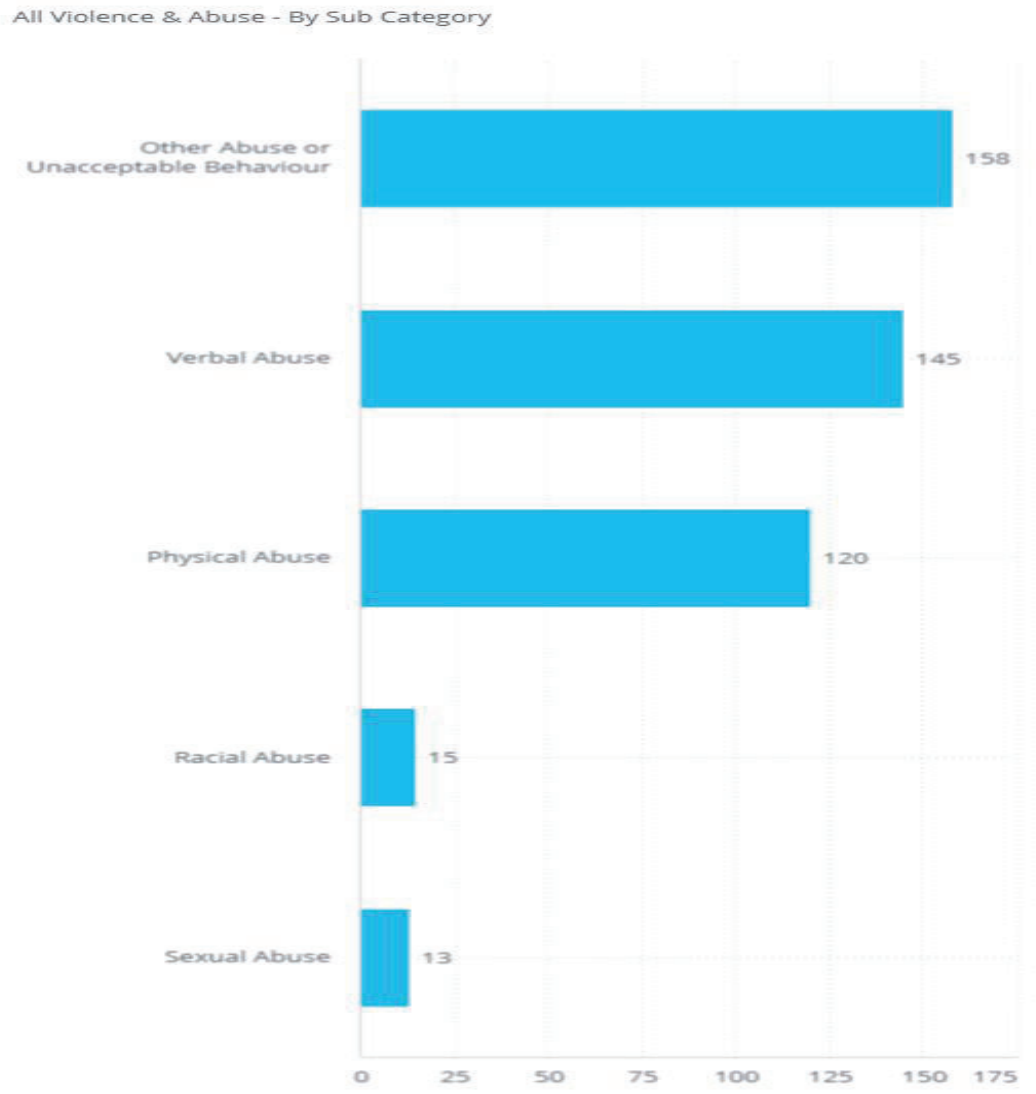
RIDDOR does not account for the emotional stress, anxiety and mental load placed on an individual through incidents that are abusive in nature. This cannot be measured through RADAR, however, the ongoing effects of violence and abuse are well documented by the Health & Safety Executive and NHS England/workforce platforms.

During financial year 2023/2024 667 reports were made with one RIDDOR event. 78% (524) incidents identified patients, visitors, members of the public as perpetrators and 52% (28) related to cognitive impairment/dementia diagnosis.



In the financial year 2022/2023, 4,432 incidents reported, with three RIDDOR events.

78% (335) were identified as patients, visitors, members of the public as perpetrators. At the time of reporting during this period, the question around cognitive impairment was not asked as part of reporting and therefore cannot be confirmed.



As part of the Trust's efforts to reduce violence and aggression against our people, we are developing implemented strategies to prevent violence and unacceptable behaviour, encouraging all clinical and non-clinical services to review practices and philosophies of care to maximise safety. The Trust has several measures in place to support staff affected by violence and aggression such as by providing safeguarding supervision to support staff who manage difficult or complex safeguarding scenarios. This supervision helps staff develop competencies, reflect on their experiences, and receive restorative support. The Staff Health and Wellbeing Department offers advice and support to all employees and managers regarding health, safety, and wellbeing within the workplace. They can be contacted via phone or email for assistance.

The Trust has appointed a Freedom to Speak Up Guardian (FTSU) and Champions who support staff experiencing incivility or violence. They encourage reporting concerns and provide strategies to manage such incidents.

At the national level, NHS England has equally introduced a confidential staff support line operated by the Samaritans, available from 7:00 am to 11:00 pm, seven days a week. This service offers free and confidential support to staff.

- **How will we monitor and measure our performance in 2025/26?**

The Trust uses the RADAR system to record incidents of violence and abuse. This data informs risk assessments and safety measures to protect staff. The Trust also promotes training and awareness on managing violence and aggression, including mandatory training sessions and the appointment of speak-up champions. These measures aim to create a safer and more supportive environment for staff, ensuring their wellbeing and ability to provide high-quality patient care. Compliance with training, risk assessments and management competencies will be key measures. Numbers of incidents will be closely monitored but are not necessarily a reliable progress indicator as the Trust wants to encourage reporting. Reports to the police will be monitored and reported, as the Trust aims to increase police reporting, with closer working with local police services.

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

The Trust provides monthly reports to the Health and Safety Committee to ensure progress against improvement targets. Quarterly reports are also provided to the Quality and Clinical Risk Committee and Audit & Risk Committee, and a bi-annual report to the Trust Board showing trends in Violence and Abuse against our people.

2.2 Our Performance against Priorities for Improvement in 2024/25

Priority 1: Improvement in Sepsis Management.

Why did we select this priority in 2024/25?

For the third year running, improving the management of sepsis and of the deteriorating patient was continued as a priority into 2024/25, particularly in the Emergency Department. An improvement programme to examine how patients are identified as at risk of sepsis and the care pathway and clinical interventions they receive was established during 2024/25. This programme is continuing to enable the cycle of improvement – including audit – to continue, to enable the Trust to understand the impact of improvement interventions and where there is further improvement required.

What was our past performance in this area?

We have previously had focused sepsis programmes, including the launch of education and training materials. This saw improvement in awareness and identification of sepsis. This was revisited in the 2024/25 improvement programme with an extensive suite of audit criteria developed.

How did we monitor and measure our performance in 2024/25?

Sepsis and deteriorating patients were monitored through comprehensive audit and ward accreditation program. A standardised audit tool had been developed to facilitate monthly data collection and analysis. The findings were regularly reviewed and shared with healthcare teams to formulate action plans and utilise continuous improvement to refine practices. Senior nursing leadership actively participated in regular compliance reviews to sustain improvements and enhance patient outcomes.

Priority 2: Reducing the Number of Complaints Citing Poor Communication

Why did we select this priority in 2024/25?

Communication is commonly cited as a problem in complaints received by the Trust as well as being identified as a thematic issue in patient surveys. Communication is a broad category, encompassing pre-hospital communication (appointment letters/ digital communications, telephone systems); in-hospital care (outpatient and inpatient) and care on and after discharge. Poor communication can result in complaints and a poor patient experience. The Trust was keen to make this a focus for improvement work in 2024/25 to improve patient experience overall and reduce the number of complaints where communication is the main cause of poor experience.

What was our past performance in this area?

The Trust received 1048 complaints in total in the previous year, this includes complaints dealt with through the formal complaints process and those dealt with informally through the PALS process. Of those complaints, 311 specifically cited communication as being the main cause for raising a complaint, although most complaints incorporate an element of communication within other issues that are raised.

The communication issues raised in those complaints where communication was the main issue are detailed below:

Communication failure with patient	112
Communication failure with relatives/carers	54
Breakdown in Communications regarding Appointments	29
Inadequate information provided	28
Conflicting information	26
Patient not listened to	15
Method / Style of communication	14
Communication failure between teams	8
Discharge plans - Lack of communication with patient/family	7
Incorrect information given	7
Communication failure within teams	4
Communication failure with other secondary provider	3
Interpreting issues	3
Communication failure with GP	1

There were 26 formal complaints and 285 informal complaints where communication was the main issue.

The communication issues arise across the Trust, however, specifically the medical teams in women and children's services, cardiology, respiratory, trauma and orthopaedics, imaging and urology are receiving the most complaints in this area.

How did we monitor and measure our performance in 2024/25?

- Monthly analysis of complaint themes Trust wide
- Patient Experience Platform analytics
- Dedicated improvement programme with audit information
- Ward accreditation metrics

How did we report our progress against achieving this priority?

Quarterly reports were submitted to the Quality and Clinical Risk Committee (sub-Committee of the Board), Patient and Family Experience Board and the Trust Executive Committee. Progress updates were also provided to the Council of Governors.

Priority 3: Reducing the Number of Falls

Why did we select this priority in 2024/25?

Reducing preventable falls- especially those that result in harm-is essential to protecting our most vulnerable patients. The impact on individuals can be severe, encompassing distress, pain, injury, loss of confidence and reduced independence. For health services, falls and falls related injuries represent a significant cost. The cost of treating a single fractured neck of femur (NOF) for the NHS on average is estimated to be around £14,000 per patient (RCP, 2018). Public Health England (2017) UK been estimated the total cost if fragility fractures at £4.4bn which includes £1.1bn for social care. Hip fractures account for around £2bn of this sum.

Throughout 2024/2025, we have been implementing a quality improvement programme focussed on falls prevention and learning in real time when a fall occurs.
and we will embed this work in maintaining our commitment to auditing, learning and enhancing patient safety

Milton Keynes University Hospital (MKUH) NHS Trust remains committed to reducing inpatient falls, particularly those that lead to injury. Reducing unwitnessed falls, ensuring adequate safeguards are in place is a key priority aligned with our falls prevention assurance framework that remains a standing priority with our vision to enhance patient experience through a culture of shared learning from incidents

What was our past performance in this area?

The annual report for 2023/24 reported 1041 inpatient falls with 3% reported as moderate harm with a further 0.2% causing severe harm. Current figures for 2024/25

report an increase of 8% in patient falls, a total of 1132 (see: figure2) with 2% reported as moderate harm with no reported severe harms. MKUH uses RADAR as our internal reporting/monitoring incident system, this is continually being reviewed and refined to ensure it is aligned with national standards set by NHS England and NICE guidelines. Falls is monitored through our internal governance framework:

All Incidents resulting in moderate or severe harm are investigated in line with the patient incident response framework. There is a Falls lead that works in partnership with the wider multidisciplinary team to focus on the quality improvement programme ensuring the patients experience is captured in learning. In addition, ensuring safeguarding process are adhered to working closely with our safeguarding team.
In 2025/2026 our aim is to take a collaborative approach to falls prevention and management with a focus on standards of care using quality improvement methodology to engage with staff, through shared learning encapsulating the patients experience, focusing on individualised holistic patient care.

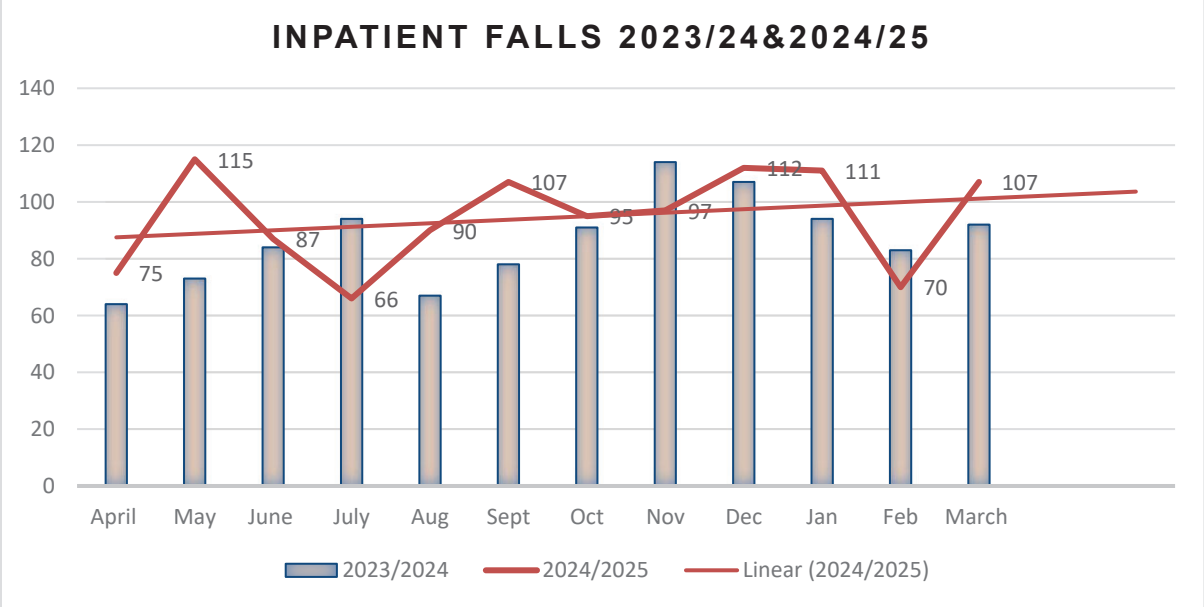


Figure 2: Inpatient falls 2023/24 compared with 2024/225

How did we monitor and measure our performance in 2024/2025?

- Harm Prevention group
- Falls assurance group

- Monthly analysis of incidents
- Monthly ward performance
- Divisional performance reviews
- Thematic incident analysis
- Quality improvement (QI) programme with QI team
- Ward accreditation metrics
- Inpatient adult metrics
- Understand the performance of similar Trusts and understand best practice.

How did we report our progress against achieving this priority?

A quarterly report was submitted to the Quality and Clinical Risk Committee (sub-Committee of the Board), Patient Safety Board and the Trust Executive Committee.

NHS England, 2017. Falls and fracture consensus statement. [pdf] Available at: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/03/falls-fracture.pdf [Accessed 14 April 2025].
National Hip Fracture Database (NHFD), 2018. NHFD 2018 Annual Report. [pdf] Available at: [Accessed 28 March 2025]. [online] NHFD-2018-Annual-Report-v101.pdf.

2.3 Statement of Assurance from the Board of Directors

During 2024/25 Milton Keynes University Hospital NHS Foundation Trust provided and/or sub-contracted 47 relevant health services.

Milton Keynes University Hospital NHS Foundation Trust has reviewed all data available to them on the quality of care in 47 of these relevant health services.

The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant health services by Milton Keynes University Hospital NHS Foundation Trust for 2024/25.

2.3.1 Clinical Coding Audit

The Trust's clinical coding audit in accordance with the relevant national guidance is ongoing with a completing timeline of June 2025 following which the outcome against mandatory percentage accuracy targets will be published.

2.3.2 Submission of Records to the Secondary Users Service

Milton Keynes University NHS Foundation Trust will submit records for 2024/25 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which will be included in the latest published data as soon as the audit is completed.

2.3.3 Information Governance Assessment Report

The Trust's Data Security and Protection Toolkit assessment for 2024/2025 is ongoing and anticipated to conclude on or before 30 June 2025.

2.4 Participation in Clinical Audits

Participation in Clinical Audits and National Confidential Enquiries

A clinical audit aims to improve patient care by reviewing services against agreed standards of care and making changes where necessary. National confidential enquiries investigate an area of health care and recommend ways to improve it.

We are committed to participating in relevant national audits and national confidential enquiries to help assess quality of healthcare nationally and to make improvements in safety and effectiveness.

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

There is evidence of good practice, learning and improvement from the National Clinical Audit Programme across the organisation. As well as participation in the national clinical audit programme, there are Quality Improvement Projects and other relevant local audits and benchmarking undertaken in the organisation.

During 2024/25, we took part in 56 national clinical audits at Milton Keynes University Hospital and 4 national confidential enquiries.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2024/25 are shown in the tables below.

	Programme / *Work stream*	**Participated at MKUH**
1.	**BAUS Data & Audit Programme:**	
	a. BAUS Penile Fracture Audit	Yes
	b. BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Yes
	c. Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes
2.	Breast and Cosmetic Implant Registry	Yes
3.	British Hernia Society Registry	No
4.	Case Mix Programme	Yes
5.	Child Health Clinical Outcome Review Programme	Yes
6.	Cleft Registry and Audit Network Database	Not applicable
7.	**Emergency Medicine QIPs:**	
	a) Adolescent Mental Health	Yes
	b) Care of Older People	Yes
	c) Time Critical Medications	Yes
8.	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	No

9.	**Falls and Fragility Fracture Audit Programme :**	
	a. Fracture Liaison Service Database	Yes
	b. National Audit of Inpatient Falls	Yes
	c. National Hip Fracture Database	Yes
10.	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Yes
11.	Maternal, Newborn and Infant Clinical Outcome Review Programme[1]	Yes
12.	Medical and Surgical Clinical Outcome Review Programme	Yes
13.	Mental Health Clinical Outcome Review Programme[1]	Not applicable
14.	**National Adult Diabetes Audit (NDA):[1]**	
	a) *National Diabetes Core Audit. Includes:* - *Care Processes and Treatment Targets* - *Complications & Mortality* - *Type 1 Diabetes* - *Learning Disability and Mental Health* - *Structured Education* - *Prisons and Secure Mental Health Settings*	Yes
	b) Diabetes Prevention Programme (DPP) Audit	Not applicable
	c) National Diabetes Footcare Audit (NDFA)	Yes
	d) National Diabetes Inpatient Safety Audit (NDISA)	Yes
	e) National Pregnancy in Diabetes Audit (NPID)	Yes
	f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	No
	g) Gestational Diabetes Audit	Yes
15.	National Audit of Cardiac Rehabilitation	Yes
16.	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)[1]	Not applicable
17.	National Audit of Care at the End of Life (NACEL)[1]	Yes
18.	National Audit of Dementia (NAD)[1]	Yes
19.	National Bariatric Surgery Registry	Not applicable
20.	**National Cancer Audit Collaborating Centre (NATCAN):**	
	a. *National Audit of Metastatic Breast Cancer (NAoMe)[1]*	Yes
	b. National Audit of Primary Breast Cancer (NAoPri)[1]	Yes
	c. National Bowel Cancer Audit (NBOCA)[1]	Yes
	d. National Kidney Cancer Audit (NKCA)[1]	Yes
	e. National Lung Cancer Audit (NLCA)[1]	Yes
	f. National Non-Hodgkin Lymphoma Audit (NNHLA)[1]	Yes
	g. National Oesophago-Gastric Cancer Audit (NOGCA)[1]	Yes
	h. National Ovarian Cancer Audit (NOCA)[1]	Yes
	i. National Pancreatic Cancer Audit (NPaCA)[1]	Yes
	j. National Prostate Cancer Audit (NPCA)[1]	Yes
21.	National Cardiac Arrest Audit (NCAA)	Yes
22.	**National Cardiac Audit Programme (NCAP):**	

	a. National Adult Cardiac Surgery Audit (NACSA)	Not applicable
	b. National Congenital Heart Disease Audit (NCHDA)	Not applicable
	c. National Heart Failure Audit (NHFA)	Yes
	d. National Audit of Cardiac Rhythm Management (CRM)	Yes
	e. Myocardial Ischaemia National Audit Project (MINAP)	Yes
	f. National Audit of Percutaneous Coronary Intervention (NAPCI)	No
	g. UK Transcatheter Aortic Valve Implantation (TAVI) Registry	No
	h. Left Atrial Appendage Occlusion (LAAO) Registry	No
	i. Patent Foramen Ovale Closure (PFOC) Registry	No
	j. Transcatheter Mitral and Tricuspid Valve (TMTV) Registry[2]	Unknown
23.	National Child Mortality Database (NCMD)[1]	N/A
24.	National Clinical Audit of Psychosis (NCAP)[1]	N/A
25.	**National Comparative Audit of Blood Transfusion:**	
	a. National Comparative Audit of NICE Quality Standard QS138	Yes
	b. National Comparative Audit of Bedside Transfusion Practice	Yes
26.	National Early Inflammatory Arthritis Audit (NEIAA)[1]	No
27.	**National Emergency Laparotomy Audit (NELA)[1]**	
	a. Laparotomy	Yes
	b. No Laparotomy[3]	Yes
28.	National Joint Registry	Yes
29.	National Major Trauma Registry [Note: Previously TARN. To commence data collection in 2024]	Yes
30.	National Maternity and Perinatal Audit (NMPA)[1]	No
31.	National Neonatal Audit Programme (NNAP)[1]	Yes
32.	National Obesity Audit (NOA)[1]	Not applicable
33.	**National Ophthalmology Database (NOD):**	
	a. Age-related Macular Degeneration Audit	No
	b. Cataract Audit	No
34.	National Paediatric Diabetes Audit (NPDA)[1]	Yes
35.	National Perinatal Mortality Review Tool	Yes
36.	National Pulmonary Hypertension Audit	Not applicable
37.	**National Respiratory Audit Programme (NRAP):[1]** [Note: previously named National Asthma and COPD Audit Programme (NACAP)]	
	a. COPD Secondary Care	Yes
	b. Pulmonary Rehabilitation	Yes
	c. Adult Asthma Secondary Care	Yes
	d. Children and Young People's Asthma Secondary Care	Yes
38.	National Vascular Registry (NVR)[1]	Not applicable
39.	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Not applicable
40.	Paediatric Intensive Care Audit Network (PICANet)[1]	Not applicable
41.	Perioperative Quality Improvement Programme	Yes

42.	**Prescribing Observatory for Mental Health (POMH):**	
	a. Rapid tranquillisation in the context of pharmacological management of acutely disturbed behaviour	Not applicable
	b. The use of melatonin	Not applicable
	c. The use of opioids in mental health services	Not applicable
43.	**Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS):**	
	a. Oncology & Reconstruction	No
	b. Trauma	No
	c. Orthognathic Surgery	No
	d. Non-melanoma skin cancers	No
	e. Oral and Dentoalveolar Surgery	No
44.	Sentinel Stroke National Audit Programme (SSNAP)[1]	Yes
45.	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes
46.	Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes
47.	UK Cystic Fibrosis Registry	No
48.	UK Renal Registry Chronic Kidney Disease Audit	Yes
49.	UK Renal Registry National Acute Kidney Injury Audit	Yes

Participation in Clinical Outcome Review Programmes 2024/25

Name of Enquiry	Did MKUH participate?	Stage / % of cases submitted
Emergency procedures in Children and Young People	Yes	100%
Juvenile Idiopathic Arthritis	Yes	17%
ICU Rehabilitation following critical illness	Yes	100%
Blood sodium – Hypnatraemia	Yes	100%
Acute Limb ischarmia	No	0%

National Clinical Audits - Improvements/Actions QIPS to Improve Quality of Care

Specialty	Project Title	Quality Improvements
Physiotherapy	National Pulmonary Rehabilitation	National Audit - Pulmonary Rehabilitation Action 1. Introduce incremental shuttle walk tests 2. Add the CRQ (chronic respiratory questionnaire) to the other questionnaires done prior to rehab 3. Research lower limb strengthening 4. Redesign programme to include targeted strengthening.
Medical Team - Child's Health	Paediatric Asthma Secondary Care	The National Respiratory Audit Programme (NRAP) has published the report Breathing Well, an assessment of respiratory care in England and Wales. Published in July-24, recommendations reviewed. Actions: • Time to gather data and submit to NRAP within the

		specific time frames given. • Signposting during asthma clinics and time needed to complete referrals. Education provided to Children & Young People (CYP) who smoke / vape. • To be seen by a nurse specialist prior to being discharged to complete management plan. Management plan available on the paediatric wards with education given. Personalised Asthma Action Plans (PAAPs) are given in nurse led asthma clinics.
Medical Team - Emergency Medicine	Pain in Children, Royal College of Emergency Medicine (RCEM)	Efforts are underway to improve triage times, ensuring faster pain assessment and treatment. Recent staff recruitment in the Children's Emergency Department will enhance triage efficiency, timely analgesia, and regular pain reassessments by Healthcare Assistants. A trial of pain clocks for reassessment was unsuccessful, so a QR code linking to a phone timer has been developed as the next improvement step. **Next Steps:** • Implement the QR code pain reassessment timer. • Ensure nurse managers regularly communicate with paediatric nurses to reinforce timely pain assessment. • Continue improving triage efficiency. • Explore paediatric nurse streaming to prioritise patients with moderate to severe pain. • Consider wider range of nurse Post Graduate Diplomas for analgesia throughout the department
Medical Team - Emergency Medicine	Royal College of Emergency Medicine (RCEM) Venous thromboembolism (VTE) in Lower Limb immobilisation 2	Develop a Trust patient information leaflet, for Venous thromboembolism (VTE) risk, symptoms and where to seek medical help. Ensure it is available in print and online and encourage use among clinicians treating patients with lower limb injuries requiring temporary immobilisation in Plaster of Paris (POP) or walking boot.
Blood Transfusion Laboratory	2022 Audit of Blood Sample Collection & Labelling (October 2022)	• Enhance access to NHS Blood Transfusion leaflets by adding a QR code to the form. • Strengthen documentation of stop times and ensure two signatures by using a ward auditing tool like Tendable. • Highlight **Transfusion-Associated Circulatory Overload** risk assessment sections for better visibility during prescription reviews. • Conduct ongoing re-audits to assess the effectiveness of implemented changes.
Maternity - Community	Reducing smoking in pregnancy	Develop a template letter to provide feedback on a pregnant woman's smoking cessation treatment plan and progress. The Electronic Patient Record (EPR) digital midwife will work with the team to establish a process for sharing this information with the named maternity healthcare professional.

Surgery – Trauma and Orthopaedics	National Hip fracture database Fracture Liaison service	A QIP approach was adopted for this national audit which has shown improved performance in national quality metrics •Dexa Scanner and Patient Flow: The flow of patients and the location of the Dexa scanner are under review following the relocation of the scanner. •Referral Rates: Efforts are being made to better understand and increase referral rates, both internally and externally
Surgery and Emergency Medicine	Neck of Femur fracture audit 2024	Neck of Femur fracture Service Evaluation audit action: • Expedite X-Rays: Enable nurses to order X-rays, when possible, to speed up patient care. • FIB Documentation: Ensure timely completion and recording of pre- and post-FIB pain scores through regular reminders and teaching, including at induction. • Early Trauma and Orthopaedic Referral: Prioritise early referral to Trauma & Orthopaedics. Vital Signs Monitoring: Ensure post-fibrillation vital signs are checked according to Royal College of Emergency Medicine guidelines.
Medicine	National Dementia Audit	A QIP approach has been adopted for this national audit which has reviewed the Dementia Pathway as a collaboration as an MDT (Multidisciplinary Team). PDSA for "What Matters to Me" Booklet: A PDSA cycle is being planned to evaluate the impact and benefits of the "What Matters to Me" booklet. All planned training sessions for next year are at full capacity
Medicine	End of Life	•Advanced Care Planning clinic is expected in 2025-26 •An education programme was developed and continues to be embedded. •EOL Care Education Resources for educating have been reviewed including a Trust-specific e-learning package. •DNACPR Video: A video was with support from the simulation team, to educate staff about DNACPR •Posters with QR Codes: Posters with QR codes linking to leaflets on DNACPR, ACP, and care of the dying patient have been created

LOCAL CLINICAL AUDITS - Improvements to Improve Quality of Care

	Quality Improvements and actions required to improve quality of care
Neonatal Growth Monitoring Audit	• **Project Title**
Knowledge and awareness of risks associated with Sodium sodium-glucose co-transporter 2 (SGLT2) inhibitors in patients and healthcare professionals and an audit of in-patient management of patients on SGLT2i	• Training & Workshops: Deliver sessions on SGLT2 inhibitors through grand rounds and journal clubs. • Awareness Campaign: Distribute posters across the hospital highlighting the risk of euglycaemic Diabetic Keto Acedosis (DKA). • Electronic Alerts: Integrate eCare notifications to warn healthcare professionals of euglycaemic DKA risks when prescribing or managing SGLT2 inhibitors.

	• Effectiveness Monitoring: Conduct follow-up surveys next year to evaluate the impact of educational initiatives.
Paediatric Early Warning Score (PEWS)	Nursing Education & Training • All nursing staff to be trained in clinical judgment for blood glucose, ketones, and blood pressure monitoring. • Encourage nurses to document concerns in eCare when parameters are abnormal. • A Quality Improvement Project, led by Practice Educators includes a structured workbook on A-E assessment. • Workbooks to be completed by February 2024, followed by face-to-face practical training. • Competency assessments to be finalised before summer 2024. PEWS Guideline Review & Implementation • Update Trust PEWS guidelines to align with eCare. • Consider adopting the National PEWS (SPOT) system when an electronic version becomes available to ensure consistency across trusts. • Delaying adoption of SPOT paper charts due to differences in scoring and risk of missed observations without adequate training. eCare Enhancements for Escalation • PEWS trigger thresholds now embedded in eCare to support escalation, mirroring adult National Early Warning Score (NEWS). • Proposal to add an escalation box in eCare to document who concerns have been escalated to. Next Steps • Finalise workbooks and begin training rollout. • Confirm strategy for adopting the National PEWS System-wide Paediatric Observations Tracking (SPOT) electronic version. • Consultants suggested adding PEWS transition risks to the Trust risk register for higher-level discussion. • Continue reinforcing Level 1 Pathway care plan activation in eCare under consultant direction.
Inpatient Colonoscopy audit	Action Plan • Standardised Checklist: Implement a colonoscopy checklist for resident doctors to ensure consistency. • Clear Documentation: The Straight to Test team or referring clinician must record a clear reason for admission. • Referral & Guidance: Ensure necessary referrals are made or clear advice is documented for patients with diabetes, epilepsy, Parkinson's disease, steroid cover, and bridging clinic needs. • Policy Updates: o Revise Trust policy on diabetes management before colonoscopy. o Clarify Trust guidelines for steroid cover.
Extracorporeal shock wave lithotripsy (ESWL) audit	Create 2 information sheets: 1. Data summary on ESWL to help inform which patients

	are most appropriate to be referred 2. Checklist of investigations to be completed when patients attend for ESWL/stone clinic review
Audit on testicular cancer at MKUH	Action Plan • Clinical Nurse Specialist (CNS) Presence at Diagnosis: Ensure a CNS is available when delivering a testicular cancer diagnosis. • Tumour Marker Testing: Repeat tumour markers for all patients 7 days post-inguinal orchidectomy before the Multidisciplinary Team (MDT) discussion.
Alcohol Withdrawal - Patients Admitted to Ward 1, 2A or SDEC through A&E	Presentation of Findings: • Share audit results at the gastro educational team meeting. • Present findings at the general medicine audit meeting. • Deliver teaching to nursing teams and resident doctors during nursing sessions and grand rounds. Policy & System Updates: • Work with colleagues to integrate a new Standard Operating Procedure (SOP) for alcohol withdrawal management into Trust policies. • Collaborate with the eCare team to modify the chlordiazepoxide power plan, ensuring Clinical Institute Withdrawal Assessment for Alcohol scoring is included before prescribing and replacing unit-based dosing. Monitoring & Reassessment: • Re-audit in 1–2 months to evaluate the impact of changes.
2024 re audit for acute upper gastrointestinal bleeding (AUGIB)	Action Plan • Focus Areas for Improvement: o Improve compliance with GBS recording. o Establish clear resumption plans for anticoagulation. • Medical Team Alerts: o Ensure Terlipressin and antibiotic prophylaxis for liver cirrhosis patients. o Emphasise appropriate Oesophagogastroduodenoscopy OGD requests. o Continue aspirin at presentation when indicated. • Next Steps: o Re-audit to assess improvements.
Nasal Fracture Clinic Documentation Audit	Implementation of 2 proformas on eCare. Re-audit to monitor effectiveness of proformas
Reduction of Venous thromboembolism (VTE) Episodes of pregnant and post	VTE reminder pop ups. The trust to ensure that the VTE electronic alert system is tailored to maternity requirements. To review and amend the VTE electronic alert to align with maternity requirements - admission to hospital, within 6 hours post birth, 72hours postnatal if still an inpatient.
Bile Acid Gastritis	To ensure that if Bile Acid Gastritis is detected during Oesophagogastroduodenoscopy (OGD) that appropriate advice and follow-up instructions are communicated to the GP. To develop a leaflet tailored for these patients containing

	comprehensive information about their condition, lifestyle modification recommendations, and more. To give a wider talk about this topic as due to absence of clear guidelines, clinicians may experience limited understanding regarding this condition. To re-audit in 3- 6 months to ensure improvement and compliance.
Improving Inpatient Falls Assessment in Geriatric Wards	Spreading awareness and encouraging the use of the falls proforma to junior doctors, getting feedback and implementing falls proforma, considering digital implementation for ease of access and junior doctors' education. These recommendations aim to improve the quality of falls assessments in geriatric patients, ultimately enhancing patient care outcomes. Ensuring easy access to the proforma and re-auditing next year after editing the document will be the next steps.
Improving the accuracy of documentation of clinical progress notes	To meet with the e CARE training team re giving an input, if necessary, in e-Care training. Grand round presentation by Anne-Marie James on the 10th of July re the effects of inaccurate documentation on coding.
A Quality Improvement Project on improving compliance of oxygen prescription with target saturations in the acute medical ward at Milton Keynes University Hospital	Actions from audit in improving compliance of oxygen prescription with target saturations in the acute medical ward at Milton Keynes University Hospital: • Posters on the wards and clerking areas in Accident & Emergency and Acute Medical Unit • Questionnaires to assess oxygen prescribing knowledge among junior doctors • Audit data presentation at departmental meeting • Email to remind all medical doctors regarding audit findings and the importance of oxygen prescription as there has been a changeover in medical trainees recently. Re-audit and data presentation in future

2.5 Participation in Clinical Research

The National Institute for Health Research (NIHR) is committed to funding health, public health and social care research that leads to improved outcomes for patients and the public and makes the health and social care system more efficient, effective and safe. Building on the success of the NIHR Clinical Research Network (CRN), a transformation programme was completed and transitioned our services from the CRN to the RDN from 1 April 2025. Our Organisation transitioned from Thames Valley and South Midlands to East of England - hosted by Norfolk and Norwich University NHS Foundation Trust.

The NIHR Research Delivery Networks (RDN) supports patients, the public and health and care organisations across England to participate in high-quality research, thereby advancing knowledge and improving care. At present, NIHR supports research being delivered through 30 specialty therapy areas and 12 regional RDNs (RRDN). These provide a network of research expertise and clinical leadership to deliver research studies on the NIHR Portfolio of studies.

MKUH is committed to delivering high quality clinical care with the aim of providing patients with the latest medical treatments and devices and offering them an additional choice where their treatment is concerned, and we work closely with stakeholders across the system to ensure we address the challenges they face and are responsive to their research needs.

2024/25 has been a successful year for research at MKUH. Over 5200 participants were recruited to participate in across 100 clinical trials and the Research and Development (R&D) Department received funding of £1,080,000 for 2025/26 to deliver the NIHR portfolio research.

Table 1. Recruitment Figures and Recruiting Studies per Speciality in FY ending 25.

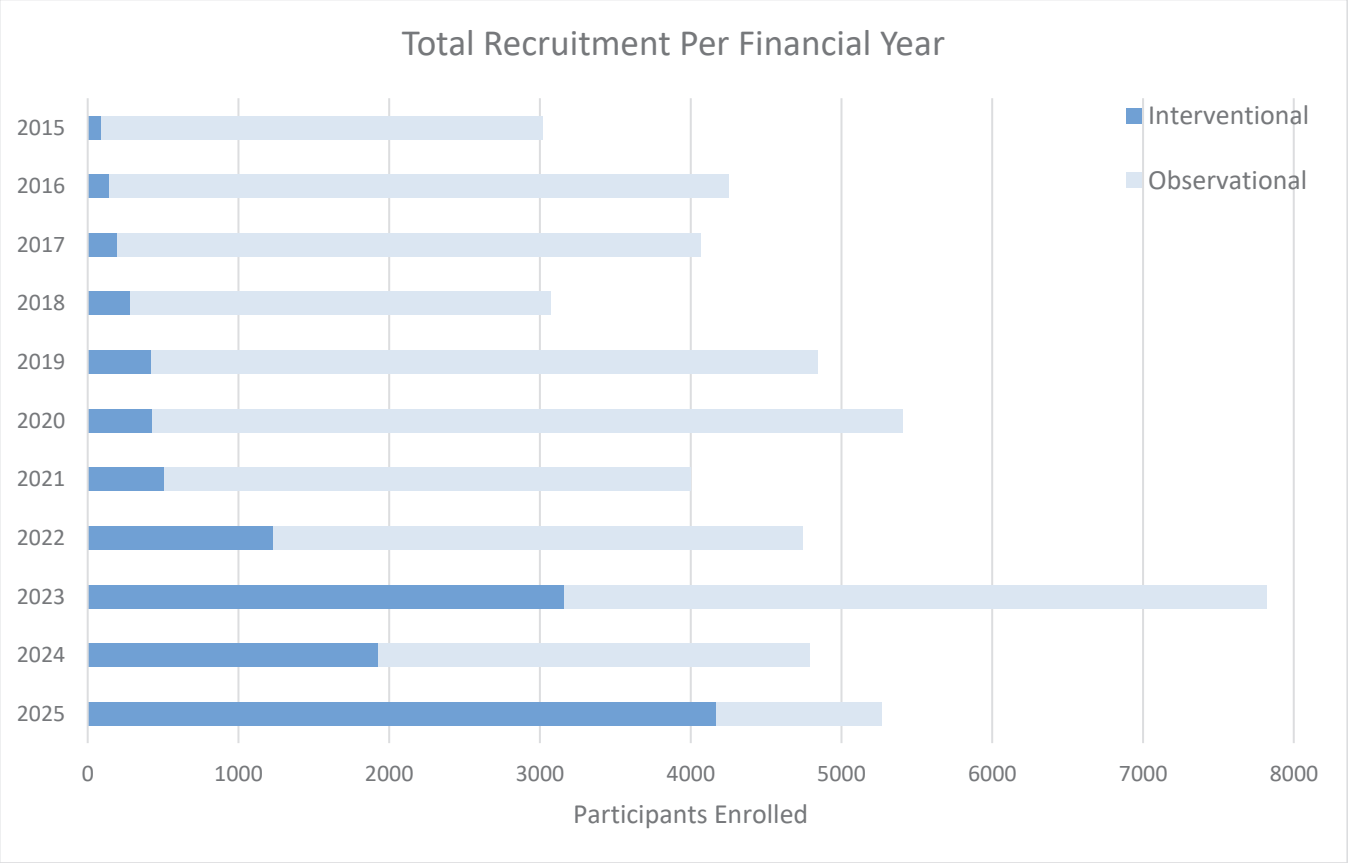
Name of Speciality	Recruitment	Number of Studies
Anaesthesia and Pain Management	94	2
Cancer	88	16
Cardiovascular	37	4
Children	12	3
Critical Care	208	4
Dermatology	2	1
Diabetes, Metabolic and Endocrine	61	3

Gastroenterology and Hepatology	65	5
Haematology	20	1
Infection	86	1
Musculoskeletal and Orthopaedics	101	6
Reproductive Health and Childbirth	3871	5
Respiratory	132	3
Stroke	15	4
Surgery	155	5
Trauma and Emergency Care	319	10
Grand Total	**5266**	**73**

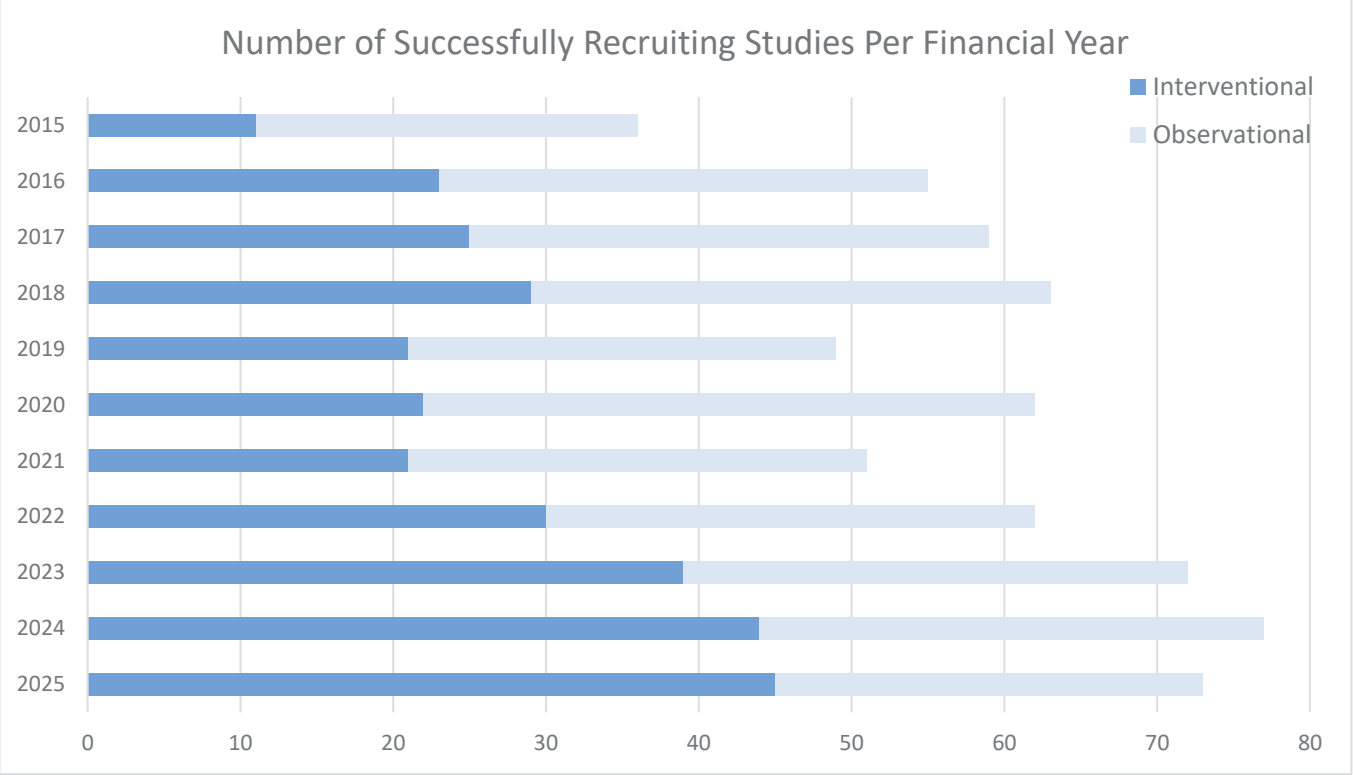
Table 2. Recruitment Figures and Recruiting Studies per Commercial Status in FY ending 25.

Type of Study	Recruitment	Number of Studies
Commercial	11	2
Non-commercial	5255	71
Grand Total	**5266**	**73**

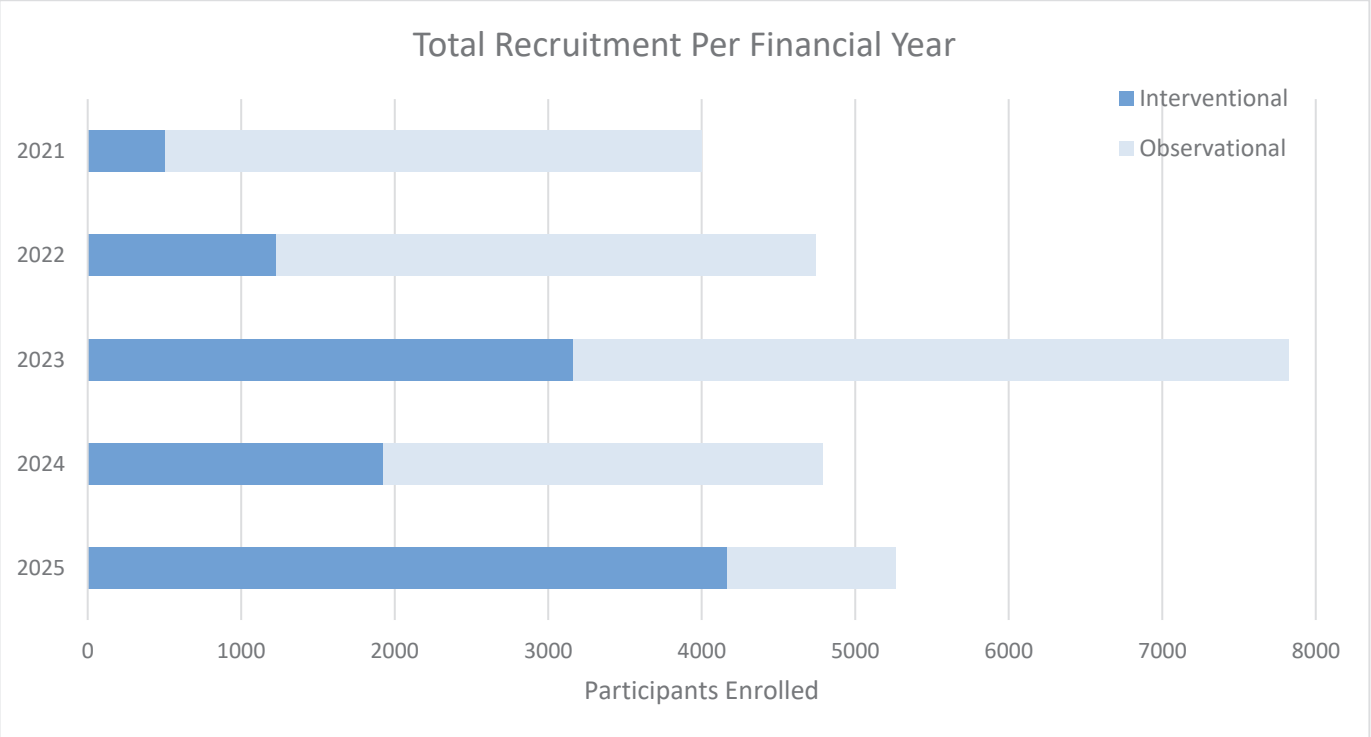
Graph 1:



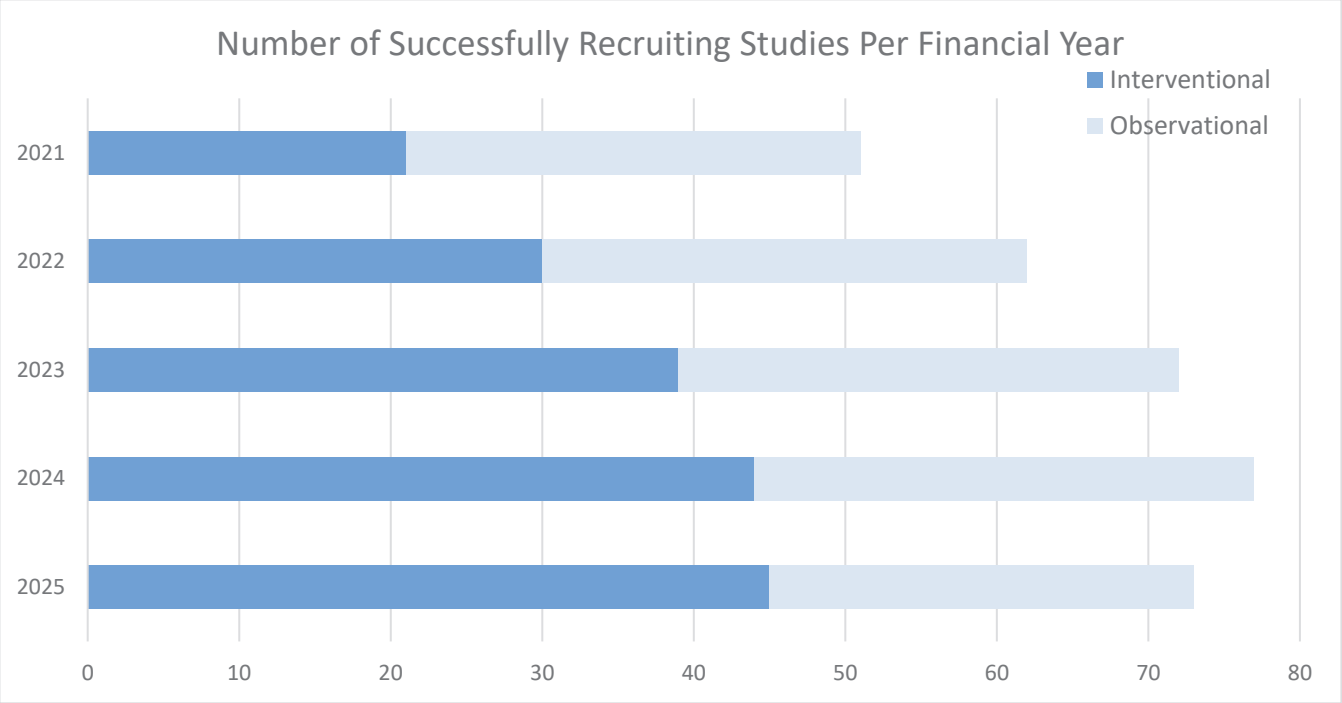
Graph 2:

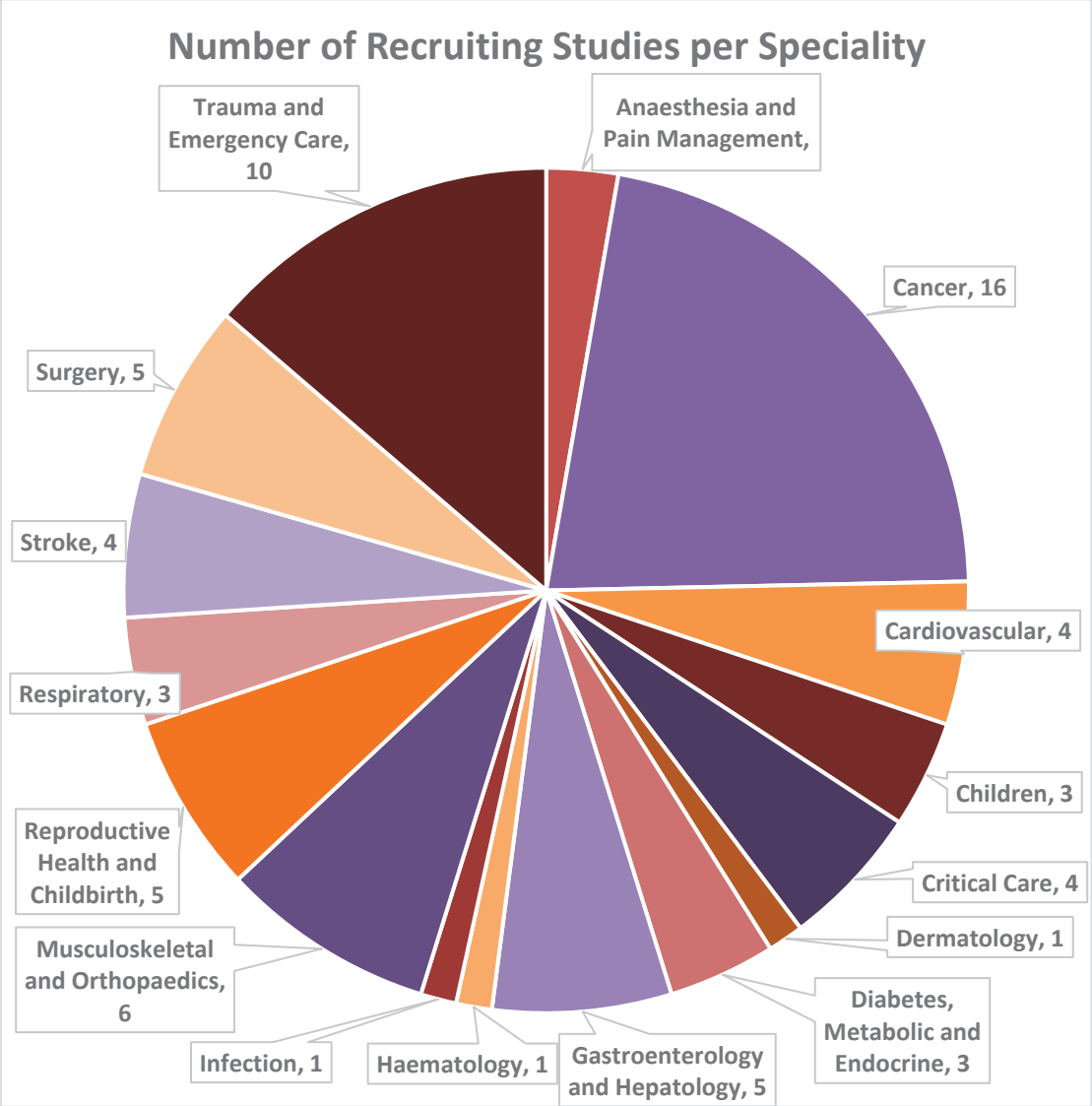


Graph 3:



Graph 4:


Number of Successfully Recruiting Studies Per Financial Year
Interventional
Observational
2021
2022
2023
2024
2025
0
10
20
30
40
50
60
70
80



Observational study: A study in which the investigators do not seek to intervene, but simply observe the course of events. There is a greater risk of selection bias than in experimental studies.

Interventional trial: A clinical study in which participants are assigned to receive one or more interventions (or no intervention) so that researchers can evaluate the effects of the interventions on biomedical or health-related outcomes. The assignments are determined by the study protocol. Participants may receive diagnostic, therapeutic, or other types of interventions

2.6 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 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 is fully registered with the CQC and has a current registration without conditions. **No enforcement action has been taken against the Trust during 01 April 2024 and 31 March 2025.**

2.6.1 Review of Compliance of Essential Standards of Quality and Safety

CQC carried out a short notice announced focused inspection of the maternity service in March 2024, looking only at the safe and well led key domains. The CQC rated maternity safety as good for safe domain. It identified that the staff had the required training and skills to work well together for the benefit of women and birthing people. The maternity service was also able to demonstrate, understanding of how to protect women and birthing people from abuse, and manage their safety well, this included staff assessing risks to women and birthing people, acting on them.

Milton Keynes Hospital's urgent and emergency services were also assessed on 10th April 2024 and were rated as **good**. They were previously rated as 'requires improvement' for Safe and Well led.

2.6.2 Overall Ratings for Milton Keynes University Hospital:

Ratings of the urgent and emergency services did not change the ratings for the hospital overall. The overall hospital rating remains as good.

Latest overall Ratings for Milton Keynes University Hospital:

Urgent and emergency services	22 October 2024	Good
Medical care (including older people's care)	30 July 2019	Good
Services for children & young people	6 March 2015	Good
Critical care	6 March 2015	Good
End of life care	29 November 2016	Good
Maternity	5 July 2023	Good
Outpatients and diagnostic imaging	6 March 2015	Good
Surgery	30 July 2019	Good

2.6.3 Key Findings from the CQC Inspection Report:

The **maternity service** managed safety incidents well and learned lessons from them. The service actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services.

People could access the service when they needed it and did not have to wait too long for treatment.

The well led domain was rated as outstanding. It was identified during the inspection that the leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

The **urgent and emergency care service** inspection in April 2024 highlighted several key strengths since the previous inspection. Patient safety incidents are managed effectively, with a strong emphasis on learning from these events. Staff are well-trained in safeguarding patients from abuse, ensuring a secure environment. Collaborative efforts with partners have established robust systems of care, which are diligently managed, monitored, and assured. The hospital also boasts a comprehensive programme of clinical and internal audits, reinforcing its commitment to high standards.

Compassionate care is a hallmark of the service, with staff consistently respecting patients' privacy and dignity. They were observed to treat individuals with kindness, empathy, and compassion, fostering a supportive atmosphere. Accessibility to care is generally good, with patients receiving the treatment they need in a timely manner. Leadership at the hospital is responsive, actively listening to staff feedback and making necessary improvements. This supportive environment helps staff feel valued and motivated in their roles.

Despite these strengths, there were areas that require attention. The handling of medicines needs to be safer and more efficient, particularly concerning the timely prescription of time-critical medicines. The safety of the environment and equipment also needs enhancement to ensure patient safety. Mental health triage processes require improvement, with a need for consistent completion of triage forms and better staff awareness of these procedures. Medical staffing levels should be aligned with national guidance to ensure adequate coverage. Additionally, governance processes need to be more effective to support the overall management of the service.

2.6.4 Areas of Outstanding Practice

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

1. The trust had invested in additional middle grade specialty doctors who were on-site and available 24/7. This was to ensure the safety of women and birthing people and improve their experience following consultation with MDT staff.

2. The specialist bereavement midwife created a bereavement garden in the hospital grounds for bereaved parents of babies and children.

3. The specialist midwife was caring and compassionate and had gone above and beyond to develop the bereavement service for bereaved women and their families.

4. The maternity service recognised and understood their women and birthing people groups and the additional challenges the women and families who accessed the service faced. Particularly around health inequalities, co-complexities and co-morbidities. As a response to these challenges, the service had created more specialist roles to support women in the hospital and community to improve the outcomes and experiences of the women.

5. The access to information by women, birthing people, staff and public about the service, performance, policies and procedures was exemplary. Women and birthing people had access to 60 information leaflets about pregnancy, condition and delivery. Women, staff and the public could also access 105 service maternity specific policies and guidelines on the website. The service had also created a maternity glossary of terms for women and several maternity areas had tour videos which were available on their website for women to access. The information on the maternity website could be translated to any language.

2.6.5 Areas of Compliance or Enforcements

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

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

- The Trust should consider ensuring the bereavement room is soundproof to improve the experience of bereaved women and families who have experienced a loss. This work has been commenced within the current estates restraints at MKUH.

- The trust should continue to improve the incidents reporting process in the service. This has continued to be monitored monthly with an upward and stable trajectory.

- The trust should continue to address the vacancy and sickness rates in maternity staffing. Workforce recruitment and retention has continued as part of the workforce modelling and is monitored at divisional and regional level.

- The trust should continue to address the high smoking rates of pregnant women at booking and post-delivery. Development of this service has continued in the past year and has an onward plan for 2025/2026.

Areas for Improvement in Urgent and Emergency Care Services:

The handling of medicines needs to be safer and more efficient, particularly concerning the timely prescription of time-critical medicines. The safety of the environment and equipment also needs enhancement to ensure patient safety. Mental health triage processes require improvement, with a need for consistent completion of triage forms and better staff awareness of these procedures. Medical staffing levels should be aligned with national guidance to ensure adequate coverage. Additionally, governance processes need to be more effective to support the overall management of the service.

Ongoing Improvement Efforts:

To address the concerns raised in the urgent and emergency care inspection report, there are ongoing improvement efforts, including observational audits and a comprehensive transformation programme of activity planned for 2025-26. Improvement activity aims to enhance the safety and efficiency of medicine handling, improve the environment and equipment, ensure consistent mental health triage processes, align staffing levels with national guidance, and strengthen governance processes.

2.7 Data Quality

The Trust continues to deliver digital innovation across a wide range of clinical and administrative information systems, improving the richness and completeness of information that is used to manage and treat our patients. Complimenting this approach, is the establishment of the MKUH Data Academy to invest in the data and analytical skills of staff and develop insight important for identifying opportunities to improve both the efficiency and effectiveness of patient care.

The Trust continues to strengthen assurance against the quality and completeness of patient data externally through national benchmarking of key patient indicators against regional and national peer groups. Secondary Uses Service (SUS) data continues to be used to benchmark data quality completeness through both the national Data Quality Maturity Index (DQMI) and Commissioning Data Set (CDS) coverage dashboards, both provided by NHS England.

For the last published month (January 2025) the Trust performed above the national average for data completeness in two key indicators: Ethnicity (98.7% for admitted and 94.4% for outpatients) and NHS number completeness (99.7% for admitted patient care and 99.9% for outpatients). For the last published month (November 2024) The Trust also scored above the national average for data completeness through the DQMI, scoring 99.7% for admitted patient care and 98.7% for outpatients. In support of the oversight of data quality, the Trust maintains an Executive-led Data Quality Governance Group with membership from across the organisation. The primary objective of the Group is to focus on key priority areas, with a view to evolving the underlying governance frameworks and processes to deliver improved outcomes.

The Trust actively uses a benchmarking tool to assess its performance against other Trusts both in terms of activity and key performance metrics. This benchmarking tool has been helpful in identifying the underlying reasons for the performance being below its peer hospitals. These issues have ranged from timeliness of data entry to different approaches to managing patient data. In addition, clinicians have used the benchmarking tool to provide healthcare intelligence to improve patient outcomes and support efficiency and cost-saving initiatives.

Whilst, the Trust still continues to feel the effects of the post COVID-19 pandemic challenge it has continued to make progress, with a particular focus on improving patient waiting times. This have been achieved by improving the arrangements in managing

waiting lists through the production of daily reports on long-waiters, with weekly meetings to ensure patients are regularly reviewed and prioritised. This is also supported by regular clinical reviews and telephone conversations with patients to offer earlier dates where appropriate and where capacity allows the Trust to do so. The Trust has also implemented a new clinic outcome system designed to improve the efficiency with which clinical staff can record Referral to Treatment outcomes for patients. Delivery of this system is also expected to drive real-time attendance outcomes for patient appointments and consequent improvement in the management of patient waiting lists.

In addition to using the benchmarking system, the Trust also continues its focus on improving waiting list data quality by utilising the nationally produced LUNA reports from NHS Digital. These reports offer an up-to-date national view of data quality from all providers in England. To supplement these reports, the Trust also continues to strengthen assurance of its Key Performance Indicators (KPIs) through a combination of third-party internal audit and a bespoke annual audit programme undertaken by the Performance team and agreed with stakeholders at the start of each financial year.
In line with the national priorities set out by NHS England in their Priorities and Operational Planning Guidance for 2025/2026, the Trust is asked to achieve the following performance standards for Referral to Treatment (RTT) by March 2026:

- a minimum of 5% improvement in the 18-week RTT position.
- an overall RTT performance of 60%.
- patients waiting 52 weeks and above to represent < 1% of the total waiting list.

The Trust acknowledges that this is a challenging ask given the additional requirements to decrease expenditure on insourcing and outsourcing and also deliver efficiency savings within the Cost Improvement Programme. With this in mind, the Trust will continue to work towards target delivery but anticipates there a risk that performance standards may not be met.

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

2.8 Qualitative Information on Deaths (While Maintaining Patient Anonymity)

Milton Keynes University Hospital NHS Foundation Trust continues to implement National Quality Board guidance regarding Learning from Deaths. This includes quarterly publication of qualitative and quantitative data on deaths through Trust Board meetings held in public.

Qualitative mortality review is undertaken by the Medical Examiners, the Coronial System, Mortality and Morbidity Meetings, Structured Judgement Reviews, and a variety of multi-agency review teams looking at deaths that occur in specific

circumstances: the peri-natal period, children, patients with learning difficulties and pregnant women.

The Trust implemented the Medical Examiner system in May 2019 and has a team of ten medical examiners who work on a sessional / part-time basis to a total of 0.7WTE. This includes local general practitioners and hospital consultants from a range of specialties to provide a breadth of clinical experience and expertise. They are supported by 2 Medical Examiner's Officers and 2 bereavement nurses. Since September 2024, the Medical Examiner system has operated nationally on a statutory basis, with all deaths (both in-hospital and in the community) being subject to Medical Examiner review. There have also been changes in the certification and registration processes and the data required to be collected by the Medical Examiners' Office.

Medical Examiners provide independent scrutiny of all hospital deaths, assessing the causes of death, the care delivered before death and facilitating feedback from bereaved families. They refer cases for further investigation through Trust processes and / or the coronial system.

Deaths with concerns raised about care delivery undergo a formal Structured Judgement Review (SJR). SJRs are also requested routinely in all deaths in surgical patients, deaths in patients with learning difficulties or autism and in deaths where there is a potential mortality alert raised by quantitative data. SJRs are carried out by trained reviewers who look at the medical records in a critical manner and comment on all phases of care. The output of the SJR is discussed at monthly departmental Mortality and Morbidity Meetings. Lessons learned are shared within the specialty and across the Trust through local Clinical Governance Meetings.

Real World Health was a third-party provider of the Clinical Outcomes Review System (CORS), the electronic interface commissioned by the Trust to provide a registry of deaths and single point-of-reference for completed SJRs across the Trust. On 25th February, without prior notice, Real World Health entered creditors voluntary liquidation and immediately stopped their services. The Trust still has access to the original CORS database which is held on Trust servers which remains functional. However, the updated cloud-based system which had been recently developed and was intended to offer the ability to analyse and present SJR data, will not be provided and the server-based registry will no longer be supported by Real World Health in case of malfunction. IT and information governance are sighted on this untimely development and discussions are taking place to find an alternative provider for this service. Alternatives being considered include use of the mortality review module provided by Radar Healthcare and the creation of an in-house, relatively low-tech but robust solution.

The Learning Disabilities Mortality Review (LeDeR) programme is set up in the Trust to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice. The Trust reported 12 deaths to the LeDeR programme from April 2024 to date. The Trust has a full-time learning disability coordinator who supports the pathway for the SJR process with LeDeR review. This takes place as part of the Bedfordshire, Luton and Milton Keynes (BLMK) review group and provides external independent review. Recommendations from the review are put into practice. Actions include improving communications with families, learning disability awareness to ensure adjustments to care are made, assessments and formal processes such as

the Deprivation of Liberty Safeguards are followed. We have a specialist Learning Disability Nurse to advise and support staff, carers, and patients.

Perinatal losses occurring in association with the Trust's services are reported through the Perinatal Mortality Review Tool (PMRT). The cases undergo investigation and external review. Learning from PMRT is sent via different forums and meetings as well as the maternity newsletter. Actions taken include reviewing and updating guidelines; the introduction of a standardised triage tool; staff education; workshops to improve foetal monitoring and strengthened governance.

Table 1. Review and Investigation of Deaths Q2 & Q3 2024

Total no. of MKUH deaths scrutinised by MEs	Jul-Sep 24	Oct-Dec 24
Adults >18 years	238	285
Children <18 years	2	7
Total no. of community and hospice deaths that have been scrutinised by a ME		
Adults >18 years	228	300
Children <18 years	0	0
Total no. of deaths the ME office has provided independent scrutiny	468	592
Total number of deaths notified to the coroner after scrutiny by a ME (all deaths, MKUH & Community)		
Adults >18 years	103	51
Children <18 years	2	7
No. of Inquests and PMs	33	33
No. of cases where *urgent* ME scrutiny is requested and achieved within requested time (total number of requests)	3(4)	13(13)
No. of deaths where ME recommend case record review i.e. SJR	57	78
Deaths where a significant concern about the quality of care provided is raised by bereaved families and carers	9	11
Deaths of those with LD and with severe mental illness	4	4
Deaths in areas where people are not expected to die, e.g. elective procedures	0	0
Deaths where learning will inform the provider's existing or planned improvement work e.g. if work is planned on improving sepsis or EOL care	22	43
No. of cases signposted to PALS by ME office	9	22
No. of complaints received about the ME office or its workforce	2	0

Table One shows a selection of the data required to be collected for the National Medical Examiners' Office for the quarter before and the quarter after the introduction of the National Medical Examiners programme on a statutory basis.

Qualitative review of deaths within the Trust runs in parallel with the quantitative reporting and analysis of data generated by Hospital Episode Statistics (HES). *Caspe Healthcare Knowledge System* (CHKS) was commissioned by MKUH until December 2024 to provide information on unadjusted mortality rates as well as several adjusted indices, notably Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Index (SHMI). These measures adjust crude mortality for factors such as patient age, medical co-morbidities, and admission diagnosis to allow for comparison across healthcare providers.

The Trust has recently contracted with *Healthcare Evaluation Data* (HED), developed by University Hospitals Birmingham NHS Trust to provide this data. The new system was shown to key stakeholders on 04 April and is expected to be operational shortly afterwards. It is intended to be more flexible, allowing for personalised reports to be created in response to local trust priorities as well as providing standard benchmarking data.

As a result of these changes, it has only been possible to provide quantitative mortality data up to December 2024, though it should be possible to generate retrospective reports to cover the period December 24- April 25.

In relation to its national peers, unadjusted mortality and HSMR are consistently in the 'mid-range' and SHMI is 'as expected'. Values for crude mortality have stayed stable over the last year (see Figure 1 below). HSMR has fallen consistently in line with national values over the same period (Figure 2). The picture with SHMI and in-hospital SHMI is slightly more complex (Figures 3&4) due to changes in the way zero-length-of stay admissions were recorded prior to October 2023. As a result of these changes, MKUH changed its position from being apparently in the highest quartile of trusts providing same-day emergency care, to being in the lowest quartile despite no change in clinical activity in this respect. Guidance issued nationally by NHS England standardised how these patient encounters were to be recorded from September 2024 which should allow for more accurate comparison of this clinical activity which is low risk from a mortality perspective but can skew mortality data if not recorded consistently across healthcare providers.

In addition to Trust-level indices, further information is provided in the form of 'alerts' where data falls outside the expected range in specific diagnostic categories. Reviews take place through monthly Mortality Review Group Meetings which have representation from the Clinical Governance teams, Clinical Coding and the Medical Examiners' Office.

Interpretation of these alerts may be challenging due to the small number of cases in individual categories. Case records are reviewed when an alert has been raised, with a view to understanding the completeness of documentation, accuracy of risk prediction and triangulating these with the qualitative review conducted by the MEs.

The only current HSMR alert is in the diagnostic category of "cardiac dysrhythmias". There were 10 deaths in the last year in this category, 9 of which were due to an admission diagnosis of atrial fibrillation, a common dysrhythmia in the elderly and often

related to either intercurrent cardiovascular or respiratory illness. The other patient was admitted to hospital after a prolonged out of hospital cardiac arrest on a background of extensive cardiac disease and was managed with palliative care after discussion about the appropriateness of invasive treatment with ICU. No SJRs were raised by the MEs due to concerns over care raised by either family members or clinicians for any of these patients.

Figures 1-3 show the position of MKUH (highlighted blue) compared to national peers for unadjusted mortality, HSMR and, SHMI – in hospital for the year to September 2024.

Figure 4 shows data for SHMI, which includes data from 30 days post-discharge and therefore data are shown for the calendar year to June 2024.

Figure 1. Unadjusted Mortality Rate

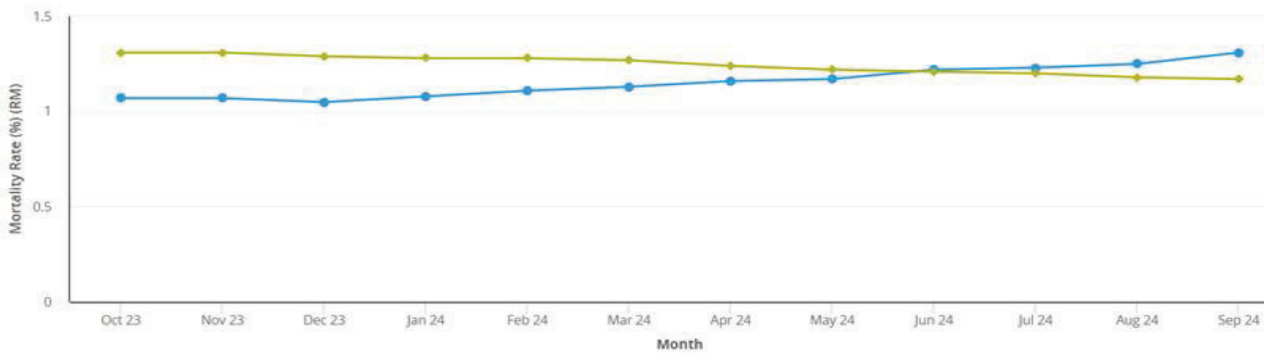


Figure 2. HSMR

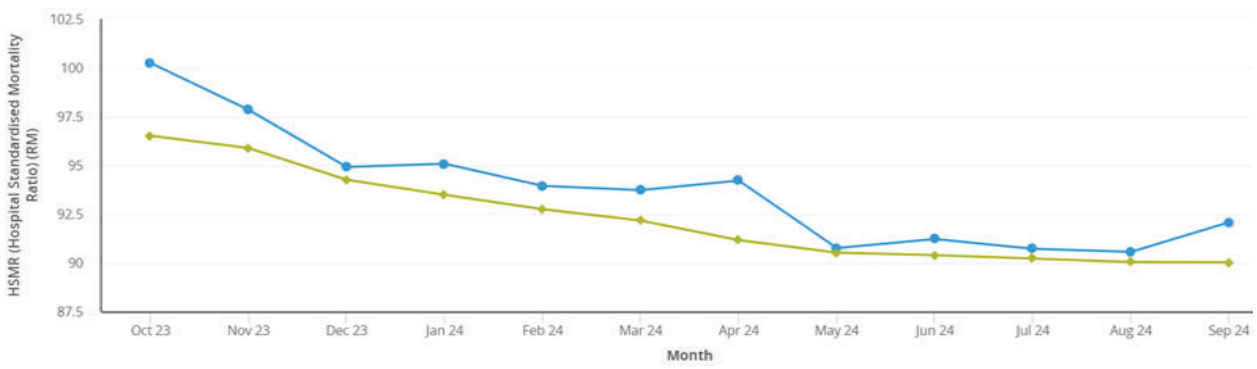


Figure 3. SHMI – in hospital

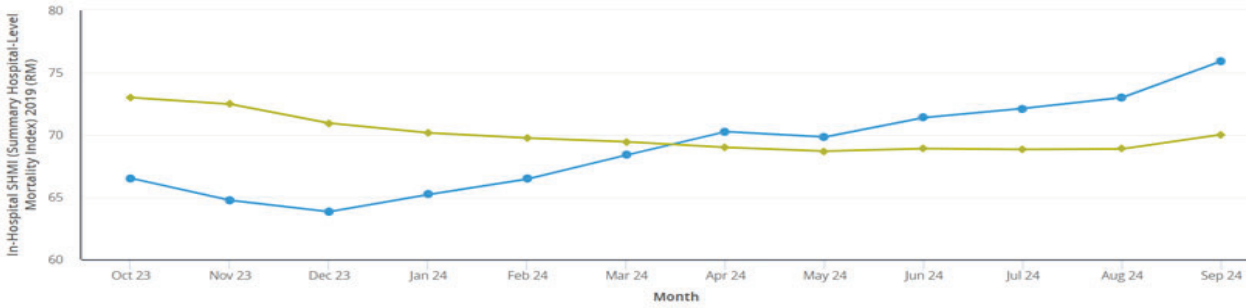
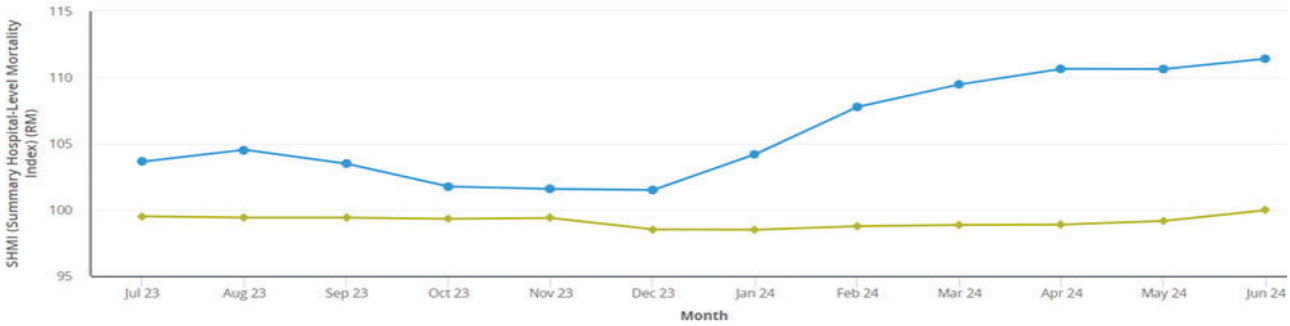


Figure 4. SHMI



2.9 Report by the Guardian of Safe Working Hours

NHS Employers introduced a new issue of national terms and conditions for doctors in training in August 2016, which affects many factors of the working life of a doctor in training. The implementation of these terms and conditions was phased, across specialties and doctors' grades between August 2016 to August 2017, resulting in all doctors in training being subject to these terms and conditions from August 2017 with update on pay uplift in 2019.

This report covers March,2024 to February,2025 and covers the system of exception reporting and the role of the Guardian.

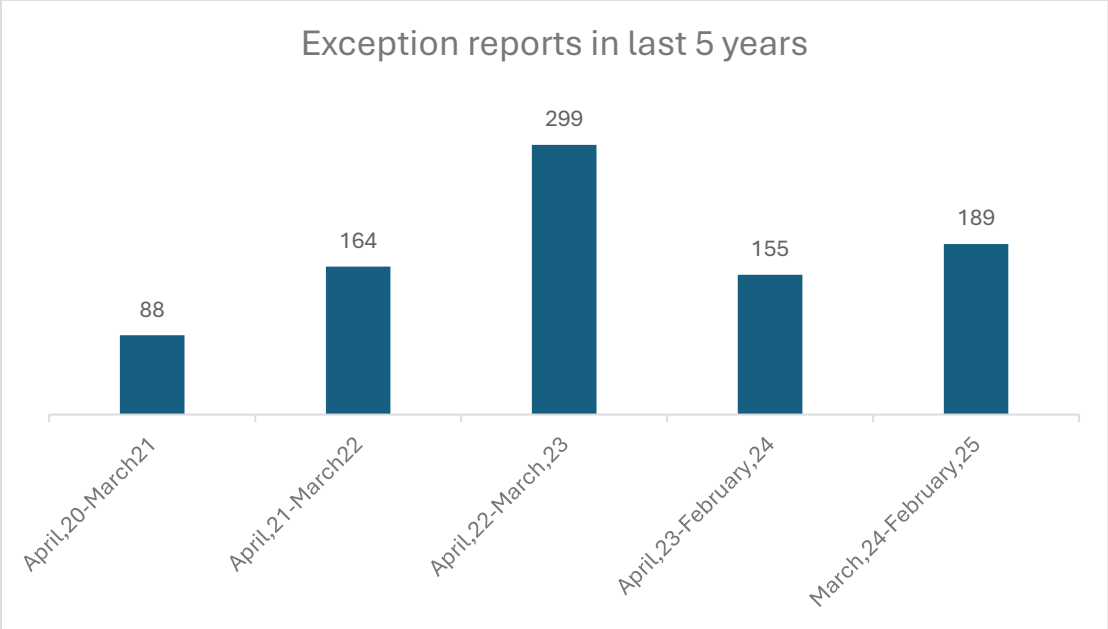
Exception reporting is the process where a trainee doctor can raise issues with their educational supervisor in relation to one or more of: their hours of work; the level of support offered to them by senior colleagues; or training opportunities which vary significantly from those described in their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

Milton Keynes University Hospital provides the following in support of the trainee doctors and the exception reporting process:

- An online exception reporting tool
- A Guardian of Safe Working Hours (consultant responsible for overseeing compliance on safe working hours)
- A Director of Medical Education (consultant responsible for overseeing the quality of educational experience)
- A Resident doctor Forum to discuss exception reports, fines and other arising issues affecting trainee doctors at the Trust.

Number of doctors/dentists in training on 2016 TCS (total)	216
Amount of time available in job plan for guardian to do the role	1PA of 4 hours per week
Admin support provided to the guardian (if any)	0.2 WTE
Amount of job-planned time for educational supervisors	0.25 PAs per trainee or 1 hour per week

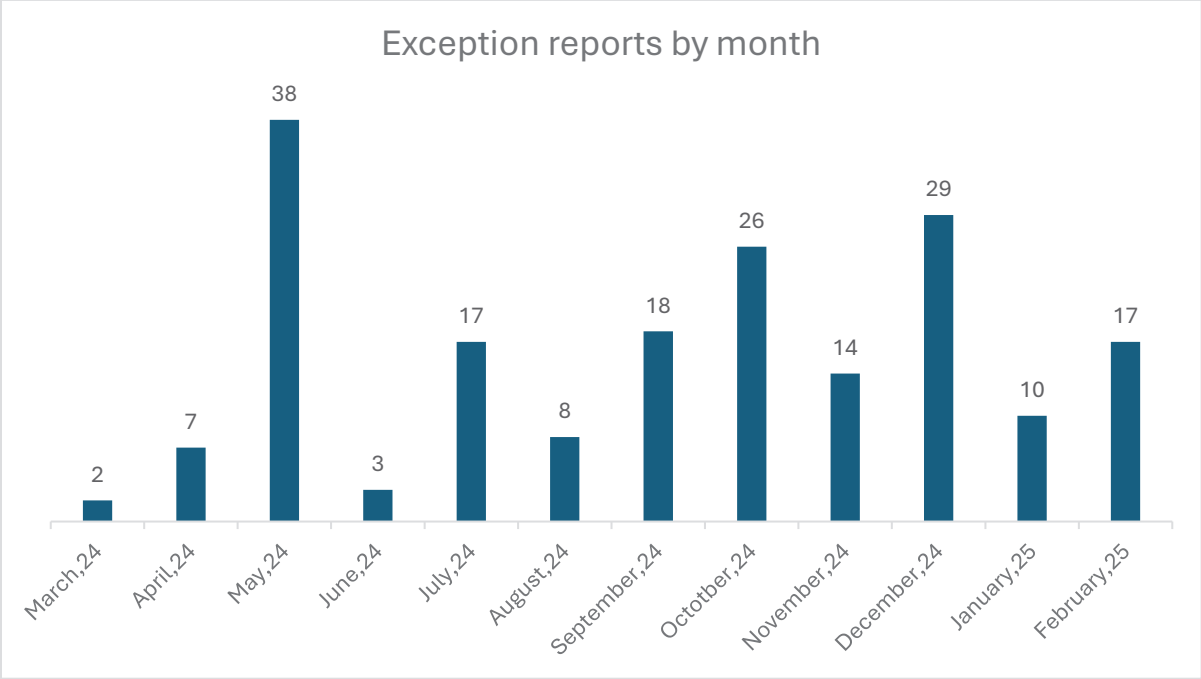
There were 189 Exception Reports Raised from March,2024 to February,2025.



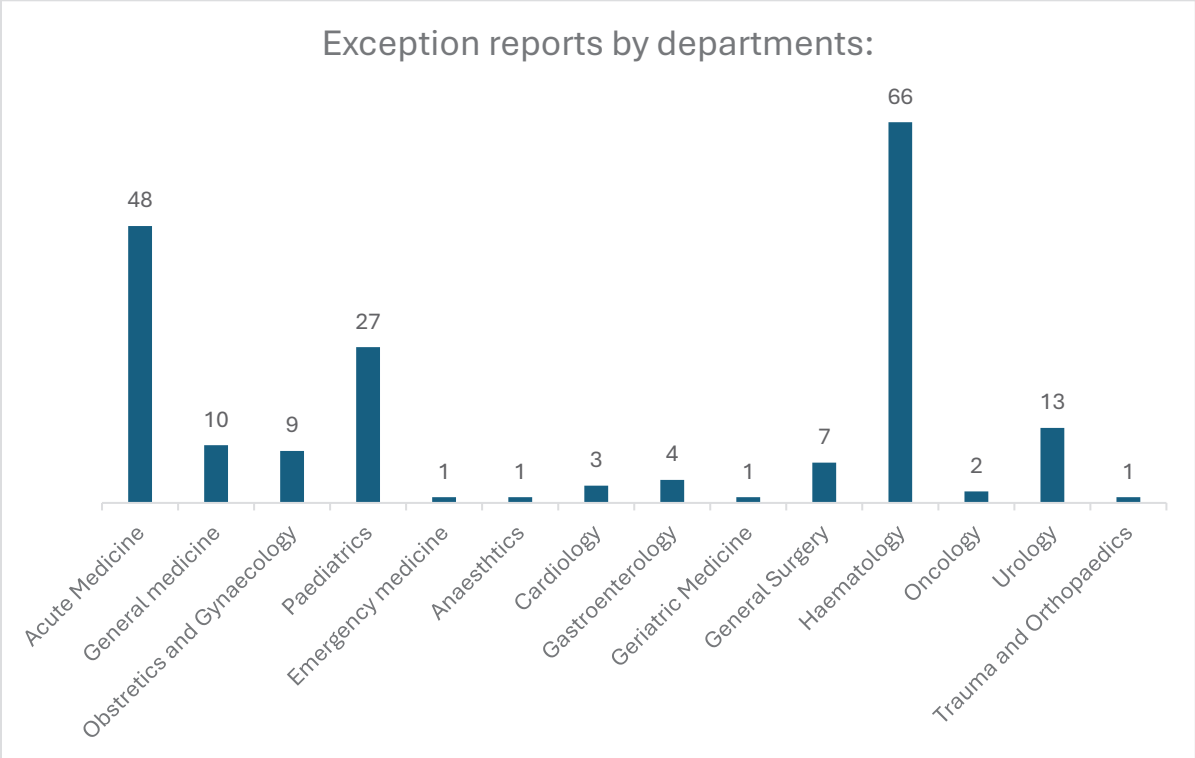
Comparison of exception reports in last 5 years:

189 exception reports were submitted last year which is similar to the previous year. There were multiple informal discussions in different departments and different level of trainees which resolved some of the issues informally.

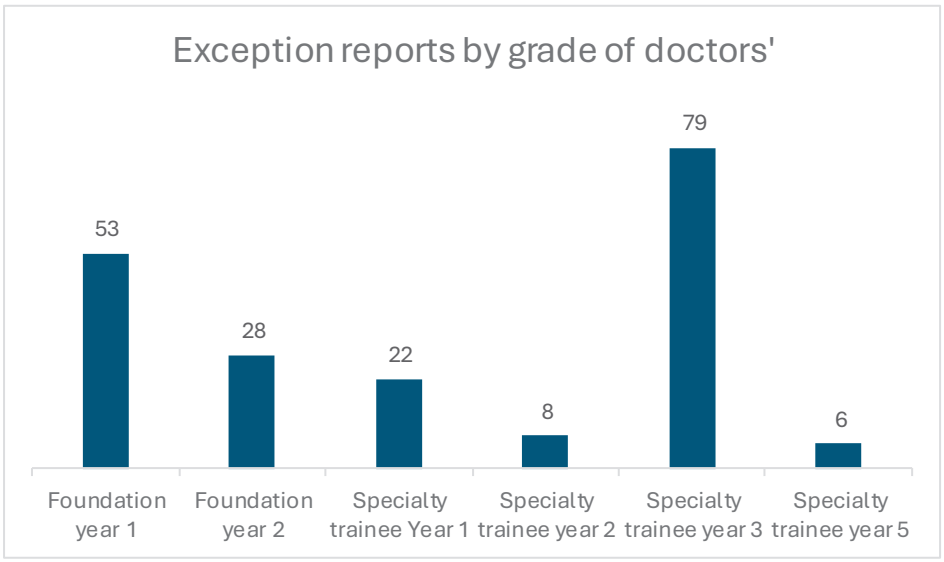
Exception Reports by Month:



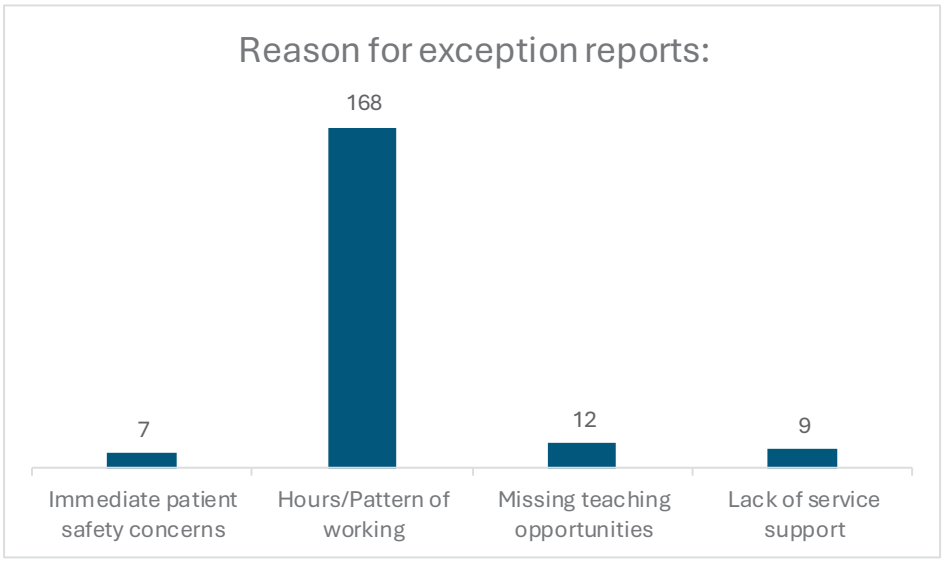
Exception Reports by Department:



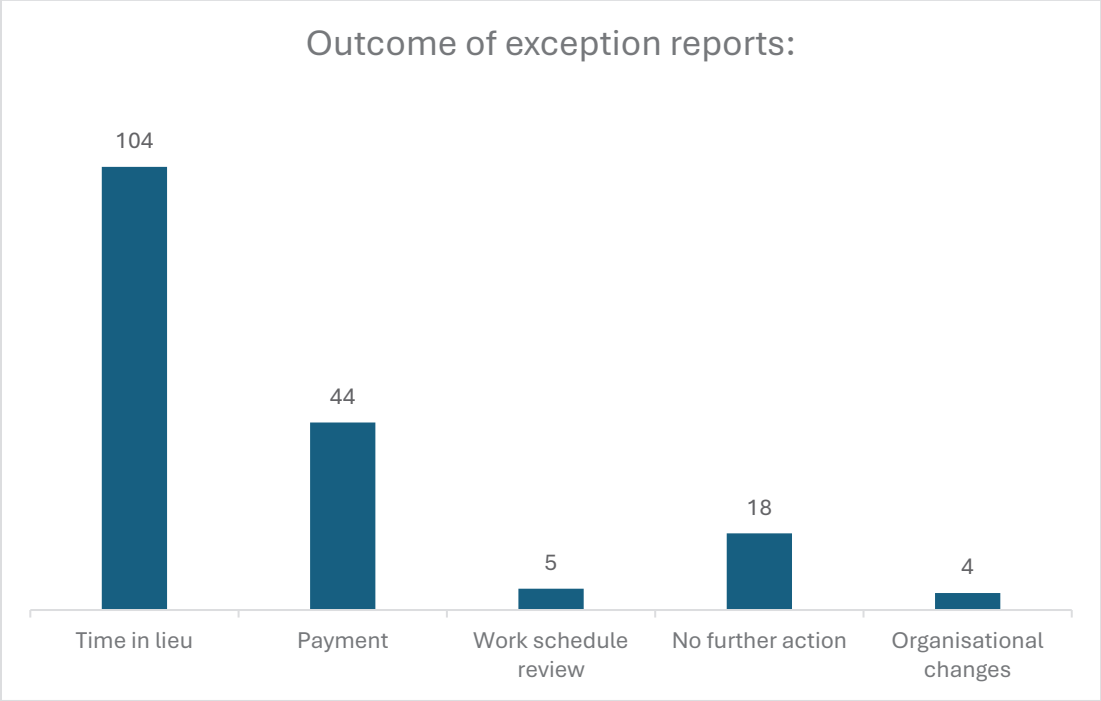
Exception Reports by Grade of Doctors:



Reasons for Exception Reporting:



Outcome of Exception Reporting:



In summary, there were 189 exception reports from March 24 – February 25, which indicates good use of exception reporting system by Resident doctors similar to previous years. Peak months of exception reporting were May, October and December. It does not follow any monthly or seasonal trend.

This year there was good use of exception reporting from all grades of doctors from foundation years to higher specialty trainee doctors which reflects Resident doctors are aware of exception reporting systems and escalating their issues.

A good number of these exception reports were from Haematology (66 out of 189, 35%), Acute medicine (48 out of 189, 25%) and Paediatrics (27 out of 189, 14%).

There were 7 exception reports with immediate safety concerns. All of them were due to low staffing levels during acute on calls, acutely unwell patients and high patients load during on calls: high volume of referrals in same day emergency care(SDEC), lack of senior support and supervision, winter pressure in Paediatric department causing Specialty registrars being busy in acute admission leaving no registrar cover for neonatal unit. Among these reports with immediate safety concerns, 1 was form acute medicine, 1 from general medicine, 1 from Obstetrics and Gynae and 4 from Paediatrics. All these exception reports were appropriately discussed with relevant departments, trainees and educational supervisors and acknowledged for regular review of on call staffing levels and maximum efforts to be given for short notice sickness cover for on call shifts especially for night and weekend on call cover.

Communications were made to the relevant educational and clinical supervisors, rota co-ordinators for adequate support to the Resident doctors specifically during on calls. There were changes implemented on the rota with additional recruitment in Paediatric

department which went live in March 2025, along with self-development time arrangements for trainees. Further feedback and review after implementation of the rota and changes will be reviewed by myself with Paediatric.

55% exception reports (104 out of 189) were resolved with time in lieu, 23% (44 out of 189) were resolved with overtime payment, 10% (18 out of 189) did not need any further additional action,5% of them resulted in some work schedule changes and organisational changes. There were staffing/ rota changes as explained before in Paediatric medicine department with additional recruitment of 2 new Resident doctors along with change of rota pattern. This rota was implemented in March 2025, further review post implementation will be carried out by myself from review and feedback from the trainees.

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

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

- Freedom to Speak Up Guardians and Champions.
- Peer to Peer (P2P) Listening Service
- Health and Wellbeing Champions
- Human Resources
- Staff Health and Wellbeing
- Equality Diversity and Inclusion networks
- Mental Health First Aiders
- Mentors and educational supervisors and preceptors.
- Line managers
- Non-executive Directors and Executive Directors
- Staff Side Unions
- Regulators

One of the routes for speaking up over concerns ranging from patient safety, quality of care, bullying, to incivility, is to use the Freedom to Speak Guardian. The team includes Freedom to Speak Guardians and a Lead Guardian, and Freedom to Speak Up Champions who act as signposts to the Guardians.

There is clear support from the Chief Executive Officer and Trust Board lead for Freedom to Speak Up. The Trust has a comprehensive and accessible Speaking Up Policy aligned with the national NHS Speaking Up Policy. This supports how colleagues can raise concerns with the Guardians and Champions and ensures that confidentiality is afforded to those individuals. Anonymity is possible and for all witnesses we strive to ensure that they are protected from detrimental behaviour that could arise from raising a concern. In addition to the policy, there is Trust-wide signage outlining the contact details of the FTSU Guardians and Champions. A contact card has also been developed that is handed out at staff induction. Feedback is given directly to colleagues who raise a concern. Feedback received from those making disclosures indicates that the facility to raise their concerns and have them heard, often for the first time, has been beneficial.

There is a dedicated email address freedomtospeakup@mkuh.nhs.uk for staff to contact the Guardians, and there is a mobile telephone line 07779 986470 as another way of contacting the Guardians, particularly for staff who do not normally use email. The extension number is 85903, or direct dial 01908 99503. There is a QR code available for staff to use as a method for raising concerns.

In 2024/25 there have been 126 cases recorded and reported to the National Guardians Office, an increase from 93 cases reported in the previous year. The Lead Guardian is using the East of England regional Guardians group and other resources to seek ideas to improve the uptake of the Guardian service. Staff who have spoken up in the past have not reported any detriment to them for doing so.

The Lead Guardian has had opportunities in 2024-25 to speak to various groups, such as managers on the Managers MK Way Induction Programme, and newly recruited Healthcare Support workers and Doctors in Training. Further opportunities to raise the FTSU profile have taken place, with an increase in activity during Speaking Up Month which focussed on 'Listening Up' and included sessions and visits to departments in collaboration with Unison to raise the service profile. The Trust offers Guardians protected time for FTSU activities, with the Lead Guardian being employed substantively.

The Trust has Freedom to Speak Up embedded into mandatory training for staff by using the three videos: Speak Up, Listen Up, and Follow Up. Compliance is at 98% across the Trust for this training.

2.11 Reporting Against Core Indicators

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

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

a) The national average for the same; and

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

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

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

SHMI Table

Domain 1: Preventing People from dying prematurely							
12. Domain of Quality	**Level**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
(a) The value and banding of the Summary Hospital-level Mortality Indicator ('SHMI') for the trust	**MKUHFT**	1.09 (Band 2)	1.16 (Band 1)	1.07 (Band 2)	1.07 (Band 2)	0.95	1.00
	National	1.0	1.0	1.0	1.0	2.0	2.0
	Other Trusts Low/High	*It is not appropriate to rank trusts by SHMI*					
(b) Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust	**MKUHFT**	47%	54%	53%	51%	42%	46%
	National	36%	36%	39%	40%	42%	44%
	Other Trusts Low / High	*12% / 59%*	*8% / 59%*	*11% / 64%*	*12% / 65%*	*16% / 66%*	*17% / 66%*

https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2023-03/shmi-data
Latest publication date: 10th April 2025. Period used: December 2023 - November 2024

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

Domain 3: Helping people to recover from episodes of ill health or following injury							
19. Domain of Quality	**Level**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
(i) The percentage of patients aged 0 to 15 readmitted to a hospital within 30 days of being discharged from a hospital	**MKUH FT**	13.7%	12.9%	13.2%	13.2%	13.9%	Not Available
	National	12.5%	11.9%	12.5%	12.8%	13.2%	
	Other Trusts Low / High	*2.4% / 97.0%*	*5.6% / 34.0%*	*3.4% / 49.1%*	*4.5% / 37.7%*	*4.4% / 69.1%*	
(ii) The percentage of patients aged 16 or over readmitted to a hospital within 30 days of being discharged from a hospital	**MKUH FT**	12.6%	14.0%	18.4%	18.5%	11.7%	
	National	14.6%	15.9%	14.6%	14.4%	15.1%	
	Other Trusts Low / High	*3.9% / 34.0%*	*3.4% / 26.5%*	*3.1% / 44.8%*	*2.5% / 27.5%*	*1.7% / 26.8%*	

https://digital.nhs.uk/data-and-information/publications/statistical/compendium-emergency-readmissions/current/emergency-readmissions-to-hospital-within-30-days-of-discharge
Latest publication date: November 2024

b. **Responsiveness to Inpatient Needs**

The Trust's Patient and Family Experience Team continues to work with the clinical teams with a view to improving the experience of patients and their families. There are a number of channels by which patients and their families are able to provide feedback, and the Trust responds proactively to these emerging messages.

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

Domain 4: Ensuring that people have a positive experience of care							
20. Domain of Quality	**Level**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Responsiveness to inpatients' personal needs	**MKUHFT**	62.6%	71.6%	Not Available	Not Available	Not Available	Not Available
	National	67.1%	74.5%				
	Other Trusts Low / High	59.5% / 84.2%	67.3% / 85.4%				

Latest publication date: March 2022
https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs

Domain 4: Ensuring that people have a positive experience of care							
20. Domain of Quality	**Level**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Staff who would recommend the trust to their family or friends	**MKUH FT**	70%	76%	Not Available	Not Available	Not Available	Not Availabl e
	Nation al	71%	74%				
	Other Trusts Low / High	*41% / 88%*	*50% / 92%*				
Patients who would recommend the trust to their family or friends (Inpatient FFT - January in each year available)	**MKUH FT**	96%	94%	94%	93%	93%	78%
	Nation al	96%	100%	99%	94%	94%	80%
	Other Trusts Low/Hi gh	80% / 100%	41% / 100%	77% / 100%	66% / 100%	74% / 100%	56% / 97%

http://www.nhsstaffsurveyresults.com/download-dashboard-data-2019/
Latest publication date: 2021
https://www.england.nhs.uk/publication/friends-and-family-test-data-february-2022/
Latest publication date: January 2025

c. **Indicator 11: % of admitted patients risk assessed for Venous thromboembolism (VTE)**

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm							
23. Domain of Quality	**Level**	**2019/20**	**2020/ 21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Patients admitted to hospital who were risk assessed for venous thromboembolism (Q3 results for each year)	**MKUHFT**	98.0%	Not Available	Not Available	Not Available	Not Available	Not Available
	National	95.3%					
	Other Trusts Low/High	72% / 100%					

https://improvement.nhs.uk/resources/vte-risk-assessment-q3-201920/
Latest publication date: March 2020

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. Indicators are usually sourced from NHS Digital to align with the NHS Outcomes Framework.

During 2024/25, the Trust made effective use of eCare, its electronic patient record system to simplify the data collection process. The Trust also keeps record of local VTE data but until NHS Digital updates the indicators on the above website, the Trust is unable to provide 'National' or 'Other Trusts Low/High' performance which historically has also been required.

MKUH local VTE performance for Q3 2024/25 was 97.2% as reported on the Trust Performance Scorecard.

NB: Due to the Trust's response to the COVID-19 pandemic, Venous thromboembolism (VTE) Assessments were suspended in 2020/21, and remained suspended in 2021/22, 2022/23, 2023/24 and 2024/25.

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

24. Domain of Quality	**Level**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
C.difficile infection rate per 100,000 bed days (Hospital-onset)	**MKUHFT**	5.1	6.5	10.5	11,5	14.7	Not Available
	National	13.6	15.4	16.3	18.3	18.8	
	Other Trusts Low / High	1 / 51.0	0 / 80.6	0 / 53.6	0 / 73.3	0 / 56.6	
	National (Acute)						
	Other Trusts Low / High						

https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts/domain-5-treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm
Latest publication date: September 2024

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

25. Domain of Quality	Level	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Rate of patient safety incidents per 100 admissions (and the rate that resulted in severe harm or death)	**MKUHFT**	40.8 (0.1)	54.1 (0.1)	TBC	TBC	TBC	TBC

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-5-treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5-6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5-4
Latest publication date: March 2022

The Trust reports patient safety incidents directly to NHS England via the Learning from Patient Safety Events (LFPSE) system. The reporting rate of all incidents decreased during 2024/25 following a move to RADAR incident reporting system. Actions were put in place to increase awareness of the importance of reporting incidents. A new design of the incident form implemented in June 2023, along with staff being more familiar with the new system, has seen a significant increase in the rate of reporting in subsequent months and years.

Comparative data between MKUH and other Trusts is currently not available, as MKUH were the first Trust to move across to NHS England's LFPSE system. There is an increasing number of Trusts that have switched from the National Reporting & Learning System (NRLS) to the LFPSE system; however benchmarking data is still not currently provided. We expect that improved benchmarking will be made available in the future.

PART 3: OTHER INFORMATION

3.1 Patient Experience

3.1.1 Complaint Response Times

The total number of complaints received for 2024/25 totalled 1230 (as recorded on Radar as of 9th April 2025). When compared to 2023/2024 this amounts to an increase of 7.5% (2023/24 n = 1135).

All complaints are triaged by severity upon receipt. The number of complaints received by severity for 2024/25 is detailed below:

Red - Severe harm	1
Amber - Moderate Harm	250
Yellow - Low Harm	964
Green - No Harm	15

In percentage terms the number of no and low-harm complaints amounts to 79.43% of total complaints received. Low and no-harm complaints are those that are usually dealt with by the PALS team on an informal basis, and are in relation to issues such as appointments, staff manner and attitude and lost property.

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

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

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

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

Divisional compliance with these timescales is monitored and reported through the Trust's scorecard which is reported to the Board monthly.

3.2 Patient Safety

3.2.1 Duty of Candour

The Trust looks to proactively be open and honest in line with the duty of candour requirements and looks to advise/include patients and/or next of kin in investigations. The Trust incident reporting policy outlines duty of candour compliance in line with national regulatory and standard contract requirements. For patient safety incidents reported as a moderate grading or above an initial apology is required where it is recognised that there have been care/service delivery omissions that have resulted in significant harm, followed by a formal written apology. This is tracked on the Trust's electronic reporting system where a dashboard reflects live compliance with both the first & second stages. Duty of candour data is included as a Trust KPI and reported at corporate governance meetings. With the implementation of the National Patient Safety Framework (PSIRF) compassionate engagement and involvement of those affected (patients and/or relatives) is one of the four defining PSIRF principles and has enabled the early involvement of patients/families in investigations

Since March 2017 a covering letter has been included in the Trust bereavement packs informing that all deaths across the organisation are investigated and, if relatives had concerns regarding care or treatment, we would look to include this in the Trust mortality reviews and feedback the findings. This process has received positive feedback and helped to give reassurances that as an organisation we look to actively learn from incidents and put in place mitigation against other similar incidents in the future. In 2019 this has evolved further with the introduction of Medical Examiners and their communications with families.

The 2024/25 Service Quality Performance Reports 100% compliance based on the Trust’s incident reporting system (Radar) for quarters 1, with 1 in quarter 2, 2 in quarter 3 and 0 in quarter 4 (against a performance denominator of 0).

3.2.2 Prevention of Future Deaths (PFDs)

The Trust received 1 PFD from HM Coroner in the year 2024 – 2025 which related to:

February 2025

Concern expressed in relation to:

- Disconnect between dietician, Speech and Language Therapy/SALT and medical/clinical staff
- Dysphagia training

The Trust’s response is not yet due, 56 days from receipt of the letter are given for a response.

3.2.3 The Patient Safety Incident Response Framework (PSIRF), Patient Safety Level 1 investigations (PSIIs) & Never Events

The Patient Safety Incident Response Framework (PSIRF) was launched across Milton Keynes University Hospital (MKUH) on 01 May 2024, following a period of limited piloting. This has started a significant shift in the way MKUH responds to patient safety incidents. It is supporting teams to focus their resource and time into reviewing patient safety incidents where there is an opportunity to learn and to avoid repetition.

The introduction of PSIRF is a major step to improving patient safety management and will greatly support MKUH to embed the key principles of a patient safety culture.Following the implementation of PSIRF, the overall number of incident reports has increased by 15%, indicating a growing culture of transparency and openness to learning. The implementation of PSIRF has also significantly improved the efficiency of incident closure. Before PSIRF, the average time to close an incident was 467 days, which has now reduced to 172 days - a 63% decrease. This reduction allows for quicker learning and action, enabling patient safety measures to be implemented more promptly. It also supports greater staff engagement, as incidents are addressed more efficiently, fostering transparency and trust in the reporting process. There has been a significant increase in the reporting of low- and no-harm incidents, with 944 additional cases recorded. This trend is positive as it reflects an improved awareness and willingness to report less severe incidents, fostering a proactive approach to patient safety.

The Serious Incident Review Group (SIRG) has been renamed as the Patient Safety Incident Review Group (PSIRG) which now has more of a focus on learning, open discussion and continues to flag key learning points from the meeting to be included in the ‘Spotlight on Safety’ section in the CEO weekly newsletter sent to all staff. It remains the governing panel responsible for approving incident reports and actions.

Outcomes (learning and actions) from learning events and M&M meetings are also shared in several different formats including monthly poster summaries, the Trust wide drop-in learning forums, team huddles/meetings and MKUH Patient Safety Hub (MS Teams site).

The Trust reported 16 Level 1 patient safety incidents on STEIS in the year which can be broken down as follows:

Incident Category	Number of Incidents
Delayed Diagnosis	3
Sub-optimal care of the deteriorating patient	5
Never events	2
Slips, Trips, Falls	2
Unexpected adult death	1
Treatment delay	1
Other – point of care equipment	1
Neonatal death	1
Total	16

The key themes seen in patient safety incidents in 2024/25 reflect those of the Trust's patient safety priorities identified in the 2023-2025 PSIRF plan. :

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

Diagnostic delays currently account for the majority of incidents relating to the Trust's safety priorities and the highest number of level 1 patient safety incident investigations (PSIIs).

Other themes identified are:

- Discharge incidents relating to medications supplied on discharge and communications with patients, relatives and third parties (for ongoing care and management) with a new quality improvement group set up focusing on discharge processes.

- Increase in violence and abuse between staff and patients/third parties to staff (verbal and physical). Process in place with Chaplaincy/Security/Health and Safety to follow through and ensure support for staff. Focus on early capacity assessments and behavioural management, de-escalation and environmental safety and security presence.

- Record keeping in eCare.. Specific challenges include the practice of 'copying and pasting' records, the delay in decision to admit documentation and speciality review documentation.

- Management of dysphagia including the adherence to care plans and guidelines. A QIP is now registered and actions have been commenced following extensive learning events and reviews.

- Management of Controlled Drugs (CDs). The medication safety team are leading a review of incidents Trust wide and developing a new tracking system for CDs to identify areas of concern.

- Admitted with and new (hospital acquired) pressure ulcers – Care, Review and Learning Group within the corporate nursing team ensures accuracy of pressure damage validation and Harm Improvement Group leading on cross-themed quality improvement work.

The Trust reported 2 Never Events in the year 2024-25 one in the Cancer Services where a patient underwent a bone marrow biopsy that was not intended for them (wrong site surgery) due to a failure to correctly confirm the patient's identification and the other in Medicine relating to the misplacement of a nasogastric tube respiratory tract which was not detected before starting a feed.

3.2.4 Midwife-to-Birth Ratio

The midwife-to-birth ratio is calculated using Birthrate Plus® as the recognised midwifery staffing workforce assessment at MKUH. Birthrate Plus® is a framework specifically aligned with midwifery workforce planning. Birthrate Plus® measures the workload for midwives arising from the needs of women starting from the initial contact in pregnancy until final discharge from midwifery care in the puerperium.

Birthrate Plus® is based on the time required to care for women. Using NICE guidance and available evidence and best practice, Birthrate Plus® calculates how many midwives would be required to meet the needs of women. A full workforce review should be undertaken as a minimum every 3 years to reassess the staffing requirements, however a review should be undertaken sooner if there is evidence of a rising birthrate, changing population demographic such as increased complex birth or service reconfiguration to ensure staffing levels meet the service demand.

A Birthrate Plus® assessment took place in 2021 and was published in May 2022 which recommended a midwife-to-birth ratio of 1:24. A Birthrate Plus® review is currently

under way and due to be completed April 2025 with publication planned date of May 2025.

The midwife-to-birth ratio is monitored on the maternity dashboard and reported in the maternity workforce overview paper. The midwife-to-birth ratio is reported through the CSU meeting, Maternity Assurance Group, Patient Safety Board and Trust Board.

Month	Midwife-to-birth ratio
March 2024	1: 28
April 2024	1: 31
May 2024	1: 26
June 2024	1: 27
July 2024	1: 30
August 2024	1: 32
September 2024	1: 32.
October 2024	1: 32.
November 2024	1: 29.
December 2024	1: 28.
January 2025	1: 29.
February 2025	1: 31.

The average ratio for the last 12-month period (March 2024 – February 2025) is 1:29.66

3.2.5 Statutory and Mandatory Training

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

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

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

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

2022/2023	95%	92%	94%	94%
2023/2024	95%	95%	96%	94%
2024/2025	95%	95%	96%	94%

Mandatory training is reported at Education Board, People and Culture Committee, Trust Board, and Trust Executive Committee (monthly) meetings.

3.3 Clinical Effectiveness

3.3.1 Cancer Waits

Nationally there continues to be a significant increase in the number of people being diagnosed living with and beyond cancer. Current figures show that one in two people will be diagnosed with cancer in their lifetime, and it is expected that by 2030 3.4 million people will be affected by a cancer diagnosis.

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

Nationally Cancer Services were asked to prioritise elements of the NHS Long Term Plan that could support early diagnosis. The roll-out of the faster diagnosis of non-specific symptoms referral pathways have commenced and will continue to be developed to support this plan. These are important building blocks towards meeting the ultimate ambition of 75% diagnosis at stage 1 and 2 by 2028.

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

Milton Keynes University Hospital cancer services team continues to strive to continue local cancer provision and has provided focus on recovery and restore programmes across specialities to reduce the times patients are waiting for cancer treatments The cancer management team are leading on developments across the faster diagnostic pathways and maintain a recovery programme enabling all speciality multidisciplinary teams' access to cancer performance targets and a live patient tracking tool. This enables the speciality team's management of cancer patients' pathways and the early identification of delays and an understanding of trends and issues. There are weekly restore and recovery meetings managed by the Head of Cancer Services with operational leads and speciality cancer leads to discuss patient level detail, harm reviews and capacity and demand management.

There is a further weekly overview of the cancer position at the Executive PTL led by the Head of Cancer Services to review outstanding actions and risks. Escalation alerts

sent to the divisional and executive leads for any pathway that is raising concerns and resulting in patient delays. The Cancer Services Operational Manager meets with the BLMK Cancer Alliance Governance Lead to review cancer breaches monthly and presents root cause analysis and risk assessments for those raising concerns and identifies actions in place. Both MKUH and BLMK ICS report the cancer positions back through their Board meetings. The Head of Cancer Services attends performance review meetings with both the BLMK Cancer Alliance and TVCN Cancer Alliance to review the local position against the network performance measures, presenting action plans and constraints against improvement trajectories.

The Trust actively works with the Cancer Alliance and both East of England and the Thames Valley Cancer Strategic Clinical Network on the new cancer standards, striving to provide a faster diagnostic pathway of 28 days to enable patients receiving treatment within the 62-day standard. There is an active cancer clinical improvement group that meets monthly chaired by the Head of Cancer services and over 2024/25 have led a combined cancer pathway improvement group between primary and secondary care. The combined meeting is held on a speciality bases per month combining the cancer leads with the primary care leads to enhance collaborative working, share lessons learnt and develop new pathways aimed to improve patient experience and outcomes.

Milton Keynes University Hospital opened the Cancer Centre in March 2020 and provide additional capacity and services to the cancer patient groups enabling additional access for patients alongside meeting living with and beyond cancer standards. This has brought together cancer services under one roof in a purpose-built facility with treatment rooms and a ward specifically designed for these patients. Over the last 5 years we have seen a 44.3% increase in outpatient referrals (23.5% Oncology and 20.8% Haematology) and a 26.3% increase in anti-cancer treatments which has seen the chemotherapy suite increase from 24 treatment chairs to 34. Ward 25 escalates the 4-bed acute assessment unit on a regular basis to increase inpatient provision to 24 beds to support patients requiring an inpatient stay. Clinic rooms are full daily with only minimal capacity for overflow clinics remaining. The wellbeing area has opened to group therapy and education sessions. This provides a valuable resource to both patients and staff.

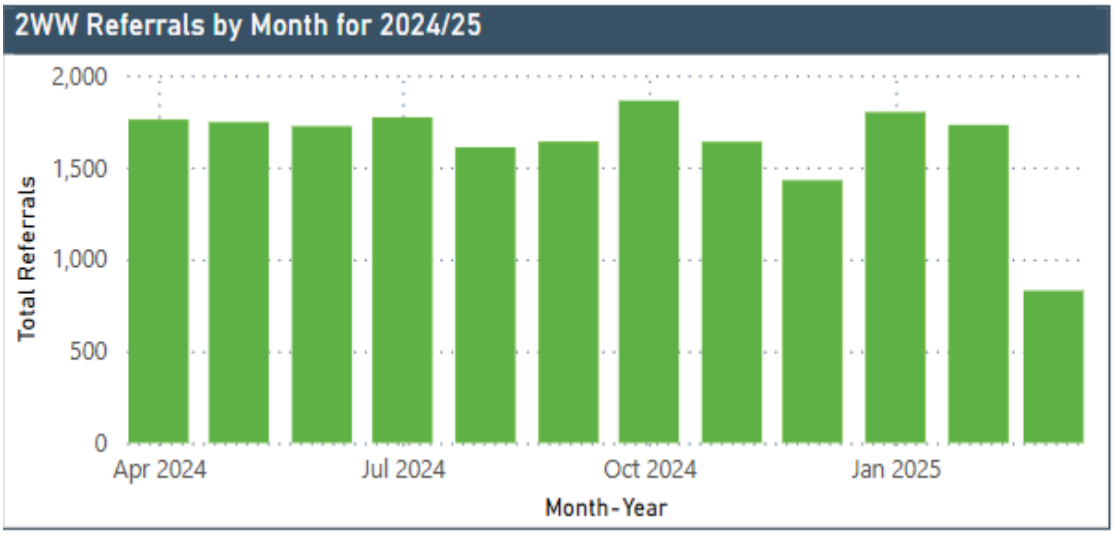
2025 will see the commencement of the local radiotherapy run by Oxford University Hospital. The radiotherapy building is alongside the Cancer Centre. to support the Milton Keynes vision of ‘treatment closer to home’. This had been a long-term action from patient experience surveys to ensure that treatment was close to where they lived with all services under one roof and focus on continuity of care 2024 also saw the cancer patient experience survey from 2023 returned seeing MKUH in the top quartile of the country for good patient experience with an overall score of 8.8 out of 10.

The Cancer Services team strive to maintain recovery to the cancer pathways utilising capacity within the independent sector as well as maximising the capacity in the hospital and Cancer Centre ensuring treatment on a priority basis. 2023/24 – 2024/25 MKUH received 21,768 urgent cancer referrals, this has seen a high demand for diagnostic services following the development to faster diagnostic pathways and this remains challenging and requires daily tracking to ensure patients are booked in priority order and escalation to capacity concerns. There has been ongoing investment via the East

of England Cancer Alliance around cancer pathways including to support extra capacity which has included Imaging and Pathology resources. Cancer performance remains challenged due to the volume of cancer referrals received, on average there are around 1800 patients tracked for a cancer diagnosis on an ongoing basis.

Cancer services achieved recognition from the national cancer team for the quality of their data tracking achieving second to top ranking position in the country for data compliance, this provides reassurance on accuracy of data and enables effective planning against clinical outcomes.

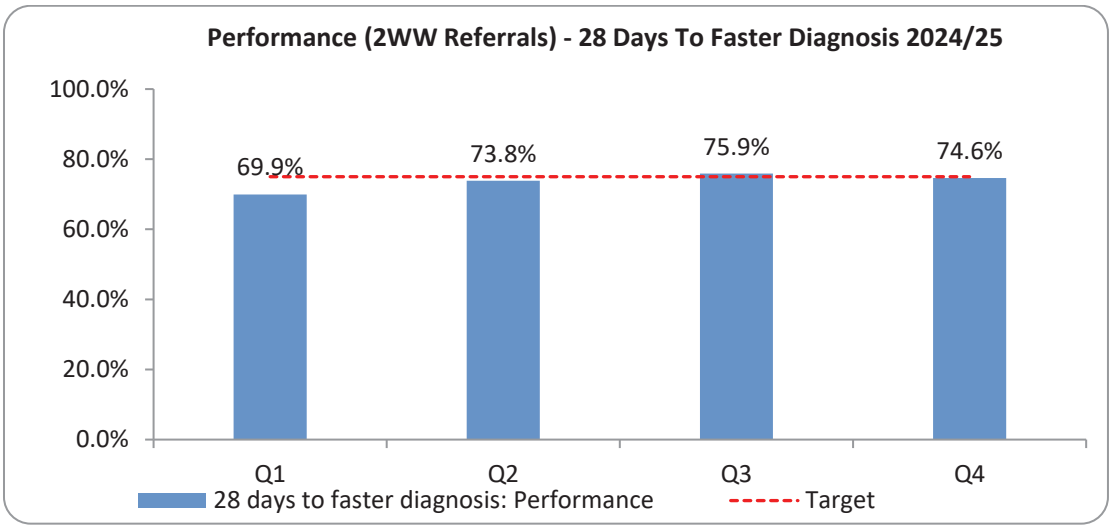
Urgent Cancer Referral Demand



Over 62-day Recovery Trajectory

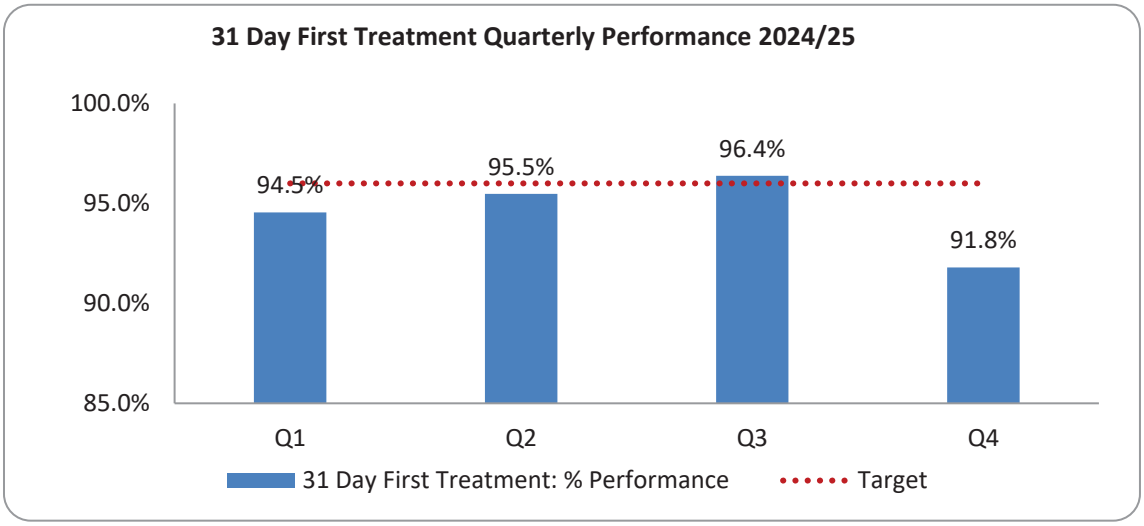
28-day Cancer Performance

(quarter 4 validation and subject to change as cancer potion not closed when report submitted)



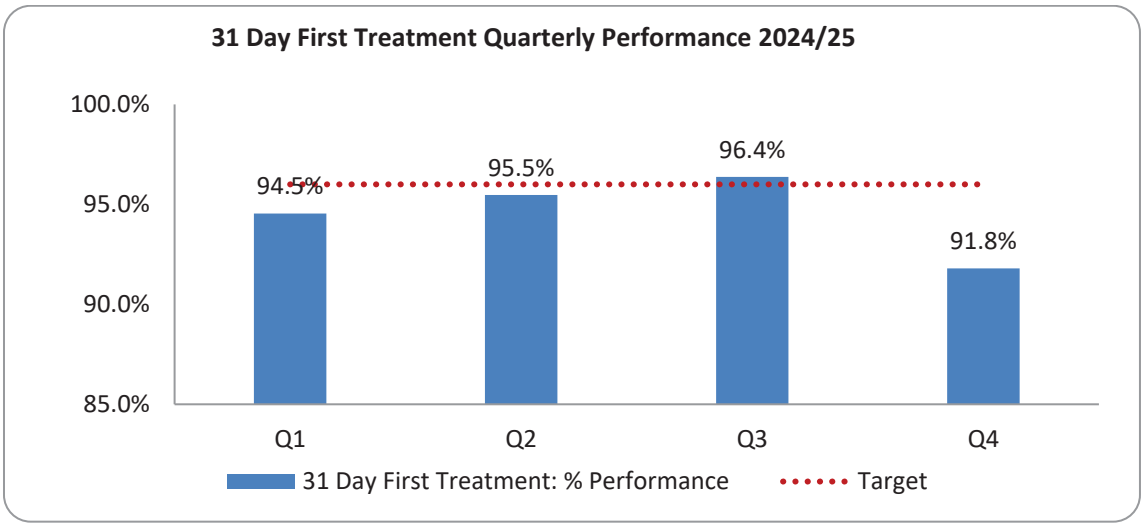
31-day cancer performance

(quarter 4 validation and subject to change as cancer potion not closed when report submitted)



62-day Cancer Performance

(quarter 4 validation and subject to change as cancer potion not closed when report submitted)



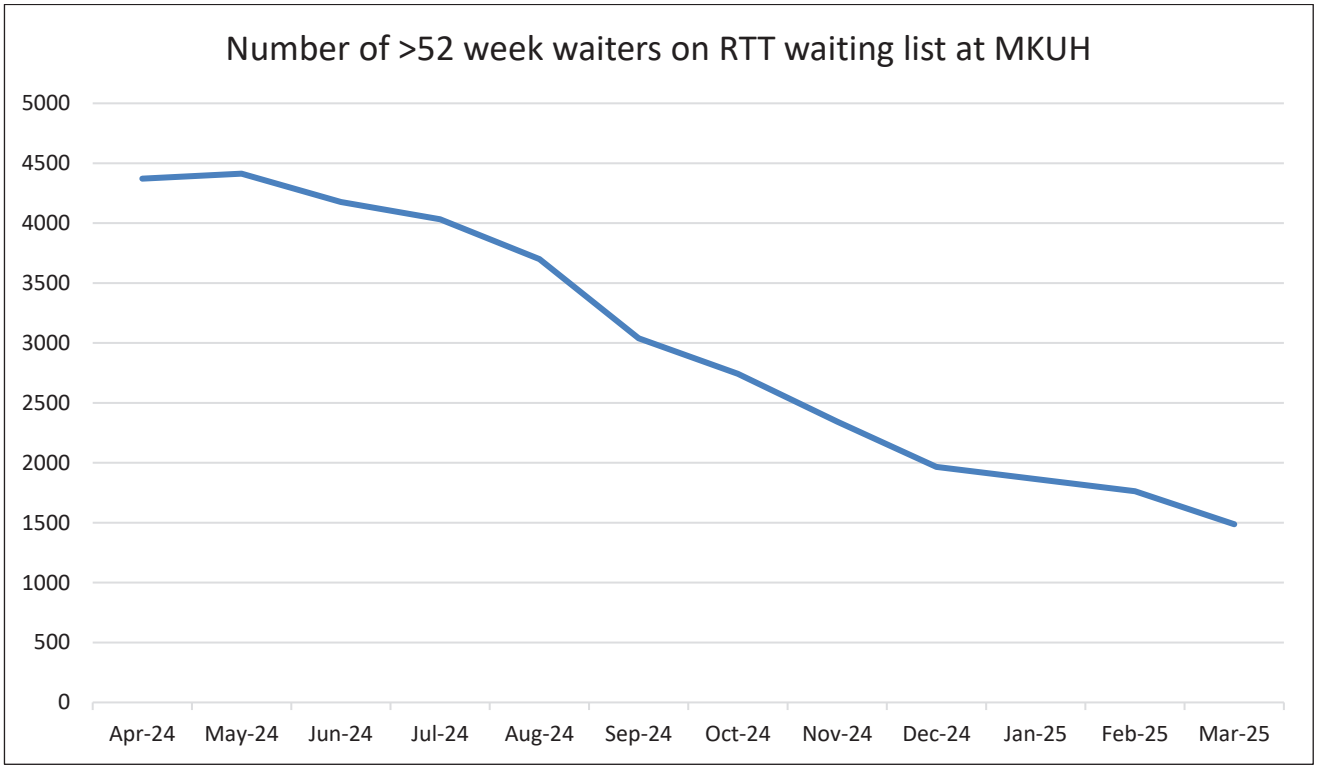
3.3.2 Long Waiting Patients

The number of patients waiting at 52 weeks and above has shown a significant reduction over the last financial year due to the implementation of various waiting list initiatives and despite a background of record winter pressures and increasing numbers of referrals.

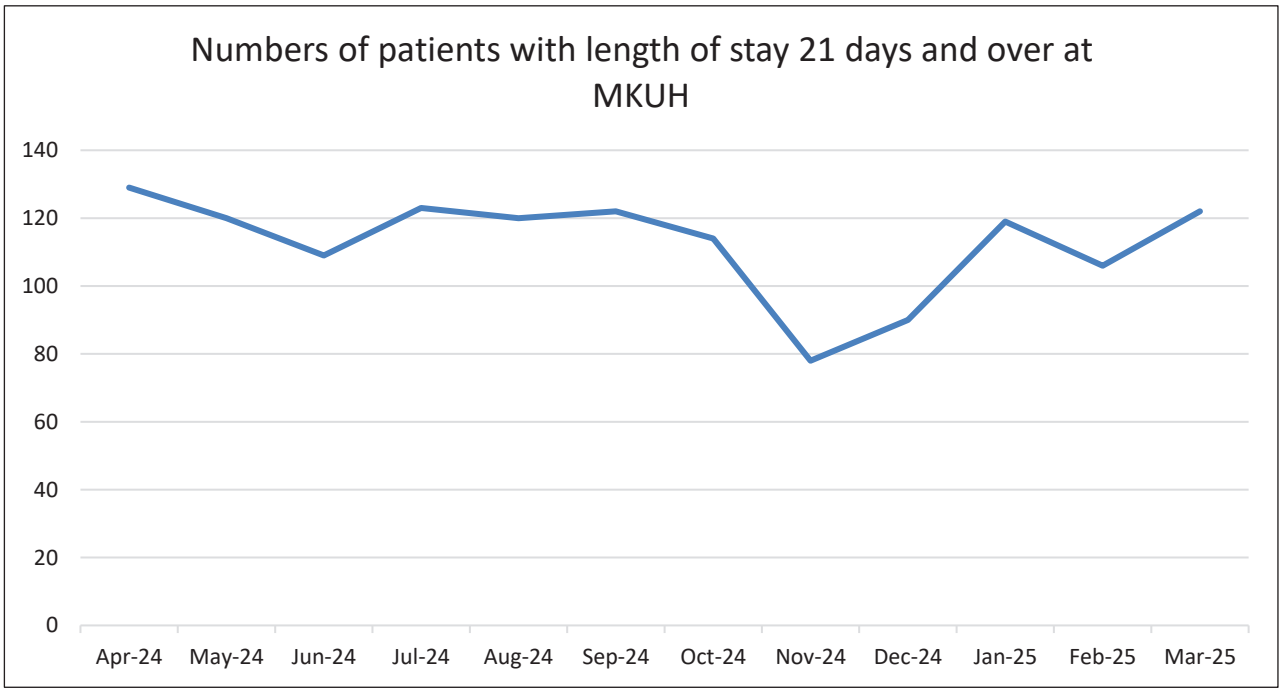
Length of stay greater than 21 days for FY24/25 has remained similar in profile to FY23/24, however this is against a background of increasing winter pressures which are eased with the Integrated Discharge Hub supporting patient discharge.

RTT 52 Week Waiters

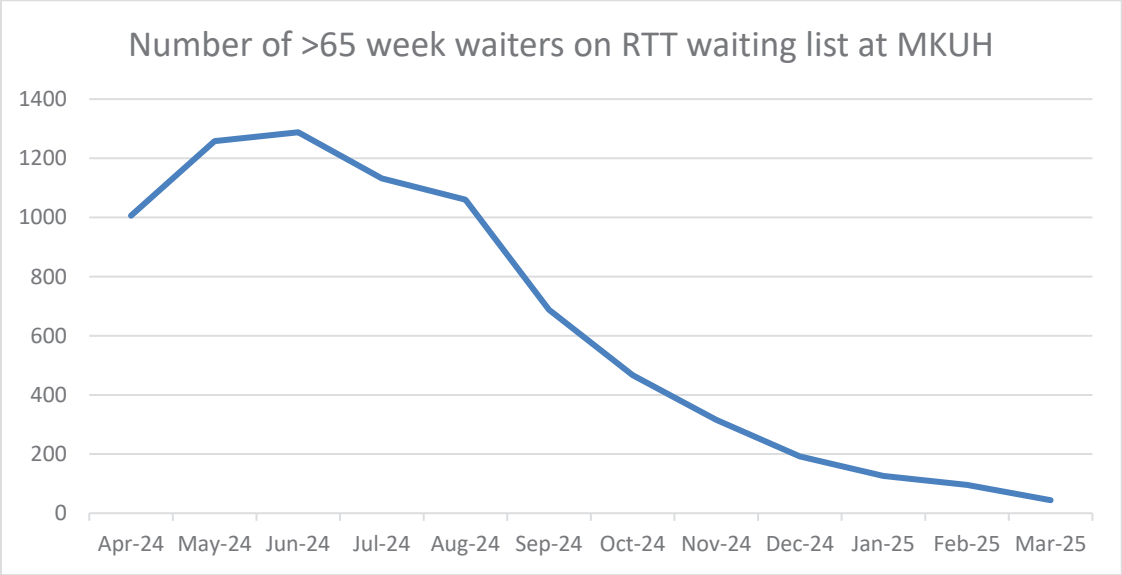
Month	April 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
Admitted	1276	1221	1165	1106	1026	775	633	548	485	433	376	316
Non Admitted	3095	3192	3011	2926	2674	2264	2109	1796	1481	1431	1387	1171
Total	4371	4413	4176	4032	3700	3039	2742	2344	1966	1864	1763	1487



Number of Super Stranded Patients (LOS>=21 Days)											
Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
129	120	109	123	120	122	114	78	90	119	106	122



Number of >65 week waiters on RTT waiting list											
Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
1006	1258	1288	1132	1060	688	467	316	192	126	96	44



3.3.3 Quality Improvement (QI)

Continuous Improvement Culture Development

As initiated by NHS-England through the Impact (Improving Patient Care Together) initiative, an Improvement Culture Self-Assessment was conducted to assess our current situation in 2024-25. In Summary:

NHS Impact Domains	Maturity RAG
1. Building a Shared Purpose	
Board and executives setting the shared purpose and vision:	Developing
Improvement work aligned to organisational priorities:	Developing
Board development to empower collective improvement leadership:	Developing
Go and see' visits:	Developing
Clear improvement methodology training and support:	Developing
Improvements measured with data and feedback:	Developing
Integrating improvement into everything we do:	Developing

Co-design and collaborate - celebrate and share successes:	Starting
Lived experience driving this work (patients, staff, communities):	Starting
2. Investing in People	
Pay attention to the culture of improvement:	Starting
What matters to staff, people using services and carers:	Progressing
Enabling staff through a coaching style of leadership:	Developing
Enabling staff to make improvements:	Progressing
3. Leadership Behaviour	
Leadership and management development strategy:	Progressing
Board, executive and senior leadership and management values and behaviours:	Progressing
Senior leadership and management acting in partnership:	Spreading
4. Capacity and capability	
Improvement capacity and capability building strategy:	Starting
Co-production:	Starting
Staff attend huddles:	Starting
Improvement capacity and capability building strategy	Starting
Clear improvement methodology training and support:	Developing
Improvements measured with data and feedback:	Developing
Co-production:	Starting
Staff attend huddles:	Starting
5. Embedding into systems	
Aligned goals:	Starting
Planning and understanding status:	Progressing
Responding to local, system, and national priorities:	Spreading

To ensure alignment with national standards, benchmarking against the NHS Impact (Improving Care Together) model remains central to our Quality Improvement (QI) strategy. The NHS Impact framework emphasises fostering a culture of collaboration, data-driven decision-making, and a patient-centred approach to care.

Over the past year, the Trust has worked on aligning its QI initiatives with the NHS Impact model, ensuring that improvements not only meet but exceed national expectations in patient safety, clinical outcomes, and service delivery.

The Trust will continue to benchmark its QI efforts against the NHS Impact framework over the next year, with a continued focus on achieving measurable improvements in patient safety, experience, and clinical effectiveness. This ongoing benchmarking ensures that all QI projects are data-driven and aim to deliver equitable care for all patients, regardless of their demographic characteristics.

Last Year: Key Achievements and Focus Areas

1. Strategic Alignment and Integration

    - Integration with the National Patient Safety Strategy (PSIRF): The Trust focused on integrating QI methodologies with the National Patient Safety Strategy. Several Patient Safety QI initiatives were launched in 2024-25 following learning events and Patient Safety Investigations in addition to those which were identified as PSIRF priorities.
    - Systems Thinking Approach with SEIPS: A systems thinking approach, using the SEIPS (Systems Engineering Initiative for Patient Safety) model, was incorporated into QI activities to enhance patient-centred improvements. This approach allowed the Trust to better understand interdependencies in patient care and optimise processes for safety and quality.
    - Embedding Proactive Care and Risk Management: The Trust shifted toward proactive care by embedding risk assessments and safety measures into everyday practice as part of QI initiatives. Risk assessments of audit outcomes identify areas for quality improvement, which helped guide the audit/QI planning for 2025-26.
    - Governance and Safety Culture: A new governance structure was introduced during 2024-25, resulting in the formation of a dedicated Patient Safety and QI team.

2. Driving and Sustaining Improvement

    - Benchmarking Against NHS Impact: The Trust continued to benchmark its QI efforts against the NHS Impact framework, ensuring that initiatives were patient-centred, data-driven, and aligned with national standards.
    - Best Practice Alignment: QI projects were benchmarked to ensure alignment with national guidance, including NICE guidelines. The use of

NICE quality standards continues to be promoted as a tool to adopt QI practices aligned with "gold standards" of care.

- Expansion of Training and QI Networks: Training programs were expanded to cover QI fundamentals, QI Practitioner courses, Nursing Preceptorships, Junior Doctors, Medical students, MK Managers, and bespoke team-specific training. Online platforms such as Future Learn, NHS Elect, HQIP, and NHS England were utilised to increase access to resources.
- Virtual Improvement Hub: A Virtual Improvement Hub was created, offering staff access to QI tools, training, and resources to support and guide staff and promote cross-functional collaboration.

3. Engaging People and Communities

    - Appreciative Inquiry (AI) Implementation: AI was further embedded to help staff and patients identify successful care practices, contributing to innovation and learning across the Trust.
    - Patient Stories: Patient stories were shared at Corporate and Divisional Governance groups, providing valuable insights and fostering a culture of continuous learning.

4. Use of Data and Technology

    - Improving Data and Addressing Disparities: Several QI projects focused on addressing data issues related to patient records, improving documentation, and better managing patient care.
    - Data gap analysis commenced for QIPs which led to changes in IT systems to assist with identification of risk and where focused QI may be required.

5. Leadership and Culture

    - Strengthening Leadership and Training: The formation of a dedicated QI team, following a governance restructure, supported the Trust's QI agenda. Staff training was made accessible at all levels, empowering individuals to engage in QI activities and lead improvement initiatives.
    - QI Project Leads: Each large-scale QI project was assigned a sponsor, lead, and coach to ensure progress, monitoring, and assurance of QI objectives.

Looking Ahead to 2025-2030: Strategic Focus

As the Trust moves into the 2025-26 period, the focus will remain on enhancing proactive care, improving data infrastructure, and ensuring consistent leadership development. By continuing to benchmark against the NHS Impact (Improving Care Together) framework, the Trust aims to ensure its QI efforts are data-driven, equitable, and aligned with national standards for patient care, safety, and experience.

The Trust Quality Improvement Strategy will guide the Trust in improving patient outcomes and care quality, setting clear goals for continuous improvement in line with national benchmarks.

3.4 Performance Against Key National Priorities

Performance against key national priorities and regulatory requirements								
Indicator	**Target and source (internal /regulatory /other)**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers*	96% (National)	99.2%	98.0%	94.5%	95.3%	95.3%	94.9%	95.4%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers*	85% (National)	83.9%	81.1%	78.5%	70.6%	61.6%	57.6%	56.1%
Maximum wait of 2 weeks from GP referral to date first seen for all cancers*	93% (National)	96.4%	94.3%	84.1%	86.5%	77.1%	77.7%	83.6%
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments*	98% (National)	100.0%	99.0%	98.3%	98.8%	98.9%	98.6%	98.7%
Maximum waiting time of 31 days for subsequent cancer treatments: surgery*	94% (National)	98.9%	98.6%	84.2%	83.6%	80.8%	79.1%	94.2%
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients*	93% (National)	96.4%	97.5%	92.1%	96.8%	98.9%	90.1%	94.7%
Referral to treatment in 18 weeks - patients on incomplete pathways**	92% (National)	87.4%	85.5%	57.8%	52.5%	47.3%	36.2%	47.8%
Diagnostic wait under 6 weeks**	99% (National)	98.7%	98.9%	83.2%	64.5%	84.5%	60.7%	68.7%
A&E treatment within 4 hours (including Urgent Care Service)**	95% (National)	91.4%	88.8%	93.1%	83.9%	79.1%	78.1%	74.5%
Cancelled operations: percentage readmitted within 28 days**	95% (National)	70.4%	86.5%	50.0%	74.3%	77.7%	79.7%	86.4%
Clostridium difficile infections in the Trust**	10 (National)	15	14	6	13	19	27	28
MRSA bacteraemia (in Trust)**	0 (National)	1	0	1	1	2	0	4

Appendices:

1 **Statement from Bedfordshire, Luton & Milton Keynes Integrated Care Board (BLMK ICB) to Milton Keynes University Hospital NHS Foundation Trust (MKUH)**

Sarah Stanley, Chief Nursing Director BLMK Integrated Care Board

2 **Healthwatch Milton Keynes response to Milton Keynes University Hospital NHS Foundation Trust Quality Account 2024-25**

Maxine Taffetani, Chief Executive Officer, Healthwatch Milton Keynes

3 **Central Bedfordshire Social Care, Health and Housing Overview and Scrutiny Committee.**

Cllr Emma Holland-Lindsay, Chair, Central Bedfordshire, Social Care Health and Housing Overview and Scrutiny Committee.

4 **Glossary of Terms & Abbreviations**

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

Statement from Bedfordshire, Luton & Milton Keynes Integrated Care Board (BLMK ICB) to Milton Keynes University Hospital NHS Foundation Trust (MKUH)

Quality Account 2024 – 2025

BLMK Integrated Care Board acknowledges receipt of the draft 2024/2025 Quality Account from Milton Keynes University Hospital NHS Foundation Trust (MKUH) and welcomes the opportunity to provide this contribution to the account.

The draft Quality Account was shared with key members of the ICB and reviewed by members of the ICB's Quality Team as part of developing our assurance statement.

The ICB recognises the detailed appraisal within this account of the Trust's ongoing commitment to the population it serves. We would also like to take this opportunity to thank all the staff at MKUH for their continued dedication during another challenging year for the NHS. The ICB would like to commend the Trust on its new initiative of the "My Thank you Scheme" to facilitate a line of direct appreciation to staff from patients and visitors which endorses high quality care delivery.

This statement was based upon information contained in the draft quality account received to the ICB 29.04.25 – the information contained within to the best of our knowledge reflects accuracy and fair appraisal of progress made against quality priorities. The ICB notes the continued prioritisation of its focus areas: Improving patient safety, enhancing patient experience, and strengthening clinical effectiveness. This has been balanced against supporting metrics such as infection rates, pressure ulcers, patient safety incidents, and mortality figures. The ICB continues to be supportive of the Quality Account priorities as we progress through 2025/26.

We recognize the efforts the Trust has continued to make to meet the requirements of the National Patient Safety Strategy and further embedding the key principles of patient safety culture. The Trust implemented the new Patient Safety Incident Response Framework (PSIRF) - its response to investigation of incidents and learning from these. This is positively addressing investigation, and closure of incidents in a shorter timeframe importantly drawing out key learning and improvement. The ICB was encouraged to see throughout the year the focus of learning is a thread woven into a variety of different formats across the Trust. This has been innovative in its delivery. The key themes identified in patient safety incidents continue to be drawn through into the Trusts PSIRF plan in terms of its priorities with underpinning improvement plans.

The CQC Adult inpatient survey from 2023 has provided clear insights into patient feedback and it was encouraging to learn of the improved scoring in terms of dietary needs and importantly confidence in staff providing care at a pivotal time when often individuals may feel vulnerable. In terms of feedback for reduction in noise at night, family updates in care and in discharge planning discussions - the Trust has used this learning to facilitate improvements within this area within 2024.

Again, regulatory inspection from the CQC has provided a lens for further appraisal of services within the Trust during 2024. We were pleased to learn of the ongoing transformation work

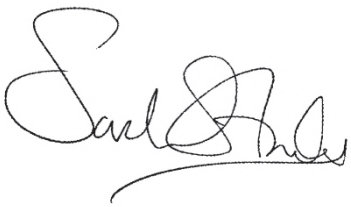
within Urgent and Emergency Services has led to a rating of good for being safe, well-led, effective, caring, and responsive. However, the CQC did identify a decline in its Maternity Survey Results. The ICB acknowledges the Trust has defined areas needing improvement and are reassured that a wide-ranging action plan already is in place and progressing. Maternity and Neonatal services continue to be both a national and local priority. MKUH continues to implement key national documents aimed at improving safety, quality and service user experiences. These include The Three-year delivery plan for Maternity and Neonatal services, Saving Babies Lives Version 3 and the Maternity Incentive Scheme. The LMNS is working closely with MKUH to progress their Equity and Equality Strategy with an aim to reducing inequalities and enhancing experiences for those who need to use translation services. MKUH has made numerous service improvements this year that are recognised in feedback from service users.

Proactive focus of the Trust has continued to show a positive shift in the decline of patients waiting over 52 weeks for treatment – the Trust has worked hard to achieve this supporting waiting list initiatives against a backdrop of winter pressures and rising referrals in.

The ICB is pleased to learn of the Trusts continuous improvement approach into tackling Cancer waiting times. This has been reflected by close monitoring of patient pathways, clinical capacity and wider system working. The Radiotherapy Centre was inaugurated in January 2025 in collaboration with Oxford University Hospital - delivering patient treatments closer into the MK landscape and improving patient experiences.

The Trust continues to develop its improvement culture, and it was interesting to gain a deeper understanding of the self-assessment benchmarks through the Impact (Improving patient care together) initiative in collaboration with NHSE. This initiative is complementary to patient safety and governance cultures, driving and sustaining improvement cultures, patient and community engagement, utilisation of data and technology, and strengthening leadership and culture. We anticipate learning more of the Trusts Quality Improvement Strategy outputs build upon further improving patient outcomes.

We continue to look forward to working in partnership with the Trust as we maintain our commitment to achieve longer, healthier lives for all in our BLMK footprint and hope that these comments are found helpful.



Sarah Stanley, Chief Nursing Officer
Executive Director Nursing & Quality

Suite 113, Milton Keynes Business Centre
Linford Wood
Milton Keynes
MK14 6GD
Tel: 01908 698800
www.healthwatchmiltonkeynes.co.uk

healthwatch
Milton Keynes

27th May 2025

Healthwatch Milton Keynes response to Milton Keynes University Hospital NHS Foundation Trust Quality Account 2024-25

Healthwatch Milton Keynes (HWMK) would like to thank Milton Keynes University Hospital NHS Foundation Trust (MKUH) for inviting us to comment on the draft Quality Account 2024-25.

Healthwatch Milton Keynes asks resident volunteers to participate in the annual review of Quality Accounts on our Quality Account Panel. Our volunteers offer a unique perspective that staff within Healthwatch might overlook because they have more detailed knowledge of local health systems and services. This year our panel had 5 members – 3 volunteers and 2 members of staff.

We were impressed by the quality of the Quality Account. All content was clear, well set out and focussed on communicating with the Patient/public reader. The Trust clearly aims to improve the accessibility of the Quality Account based on the feedback of local Healthwatch and other stakeholders.

There was a clear and informative introduction to the Quality Account which set the tone for a generally accessible report. The introduction set out the strategic links between the Trust's strategy and other national/local driving strategies and the quality account with clarity. The CEO's introduction was reader friendly and informative, highlighting the ambitions of the Trust to meet the growing demand of residents, welcoming developments at bringing care closure to home and improving patient care through developments including the radiotherapy centre, community diagnostic centres, Oak wards and the Women and Children's Centre.

Milton Keynes University Hospital Trust should be proud of its work and performance in relation to reducing waiting times. Equally, there was evidence through detailed narratives of approaches to workforce communications, training and audit how quality, experience and safety issues are highlighted and monitored.

This year Healthwatch Milton Keynes has undertaken the following activities in and around the work of the Trust:

- Appreciative interviews with patients following discharge from the Integrated Discharge Hub
- On ward observations and interviews with staff to determine the quality of provision of translation and interpreter support
- Attendance to the Trust's Patient and Family Experience Board 4 times per year
- Attendance at the Trust's Council of Governors via appointed Healthwatch Governor

The Healthwatch Quality Accounts Panel welcome the 2025-26 priorities, and support continued focus on sepsis management and complaints. Concerning though, is a lack of detail about the past performance on sepsis management initiatives themselves and would challenge the Trust that statistical and/or patient experience accounts be used to highlight what has improved, what are the continued challenges and what the Trust will be using as their benchmark to "maintain momentum".

Likewise, despite a year of focus on Complaints, where communication failure is cited, a deteriorating position was noted and there is insufficient narrative on the initiatives or activities implemented to address and resolve this challenge. The Quality Accounts panel felt it would be helpful to also understand complaints as a percentage of all hospital visits/patients.

With regards to Priority 3 – Reduction in violence and abuse, Healthwatch MK would expect to see in coming months greater detail about the specific challenges and different initiatives implemented regarding incidents perpetrated by patients, relatives and third parties and the proportion of those individuals deemed to have cognitive impairment/dementia diagnosis.

On the reporting of progress against 2024-25 quality priorities: **Priority 1: Improvement in sepsis management; Priority 2: Reducing the number of complaints citing poor communication; and Priority 3: Reducing the number of falls** we determined that there was insufficient explanation of activities and interventions that were effective/ineffective on the journey to improving quality, safety and patient experience. Within the account there are both statistical tables that detail deteriorating performance and an absence of narrative regarding that performance.

Whilst noting that two of the three priorities are being carried over to 2025-26 for continued action, explanatory detail about deteriorating performance (i.e. increase in complaints and falls) could provide a narrative which supports residents to understand whether there are underlying factors which contribute to stagnant or deteriorating performance, or specific challenges in implementing improvements. As detailed, the quality account doesn't help the

reader to understand whether the work undertaken by the trust against quality priorities has any degree of impact.

Highlighting patient experience of maternity care and the actions in place to address safety and patient experience is clear. We were pleased to see some elements of learning and effectiveness as noted in CQC reports such as time critical medications challenges and inpatient diabetes - these are issues residents discuss with Healthwatch MK routinely and we would suggest a future priority on the safety of patients with long term conditions during inpatient stays.

Regarding discharge incidents relating to medication on discharge and communications with patients, relatives and third parties: This is a theme communicated by the public to Healthwatch Milton Keynes regularly. We remain concerned at the consistent level of super stranded patients and the repeated theme of these figures dropping during Winter. This decrease in long stays coincides with an increase in negative experience feedback to Healthwatch Milton Keynes from these patients or their relatives, indicating that Winter pressure on the Trust results in swifter, but not always appropriate discharge. We would like to see greater use of Healthwatch Milton Keynes' appreciative inquiries with patients being discharged from the new Integrated Discharge hub informing improvements to more consistent discharge processes for people, as well as improving the involvement of patient experience in Quality Improvement projects across the Trust.

The Trusts reduction in 65- and 52-week Referral to Treatment waiting lists are impressive. Waiting times for elective care are of significant concern to the public and the section on data quality could benefit from more narrative aimed toward residents/patients.

The report gets harder to follow as it continues - from the ***Quality Information on Deaths*** - where the level of detail beings to feel more internal and challenging for the resident to follow.

The Quality Accounts panel wished to note commendable areas of the Quality account, including:

- Clear details of CQC ratings at the Trust and highlights on both outstanding areas of practice, and areas for improvement.
- Improvements made to maternity care, as well as transparent reflection of the results Maternity survey
- Contribution to Clinical Audit and National Confidential Enquiries
- Growth in numbers of patients involved in research
- Reduction in Referral to Treatment waiting times
- That the implementation of PSIRF has resulted in the increase of incidents being reported and improvements toward learning from incidents from the workforce.

Healthwatch Milton Keynes has the following recommendations against the report prior to publication:

1) Include narrative against specific initiatives and activities to address priorities that go beyond meeting structures and huddles, e.g. what training is rolled out and how staff are supported as well as challenged on existing practice
2) Use the Quality Account as an opportunity to discuss Trust challenges regarding ***Performance against key national priorities and regulatory requirements***
3) Detail how the Trust Council of Governors will receive information about ongoing performance against quality priorities, so that residents can better understand how Governors will engage their communities on these priorities, and hold non-executive directors to account

Healthwatch Milton Keynes thanks Milton Keynes University Hospital NHS Foundation Trust for presenting their draft Quality Accounts for 2024-25.

Kind regards

Maxine Taffetani
Chief Executive Officer
Healthwatch Milton Keynes

Statement from Social Care Health and Housing Overview and Scrutiny Committee

Central Bedfordshire Council's Social Care Health and Housing Overview and Scrutiny Committee holds decision-makers to account for improving outcomes and services for the residents of Central Bedfordshire. As a critical friend to the Trust, we are pleased to have an opportunity to provide feedback on the Trust's Quality Account for Milton Keynes University Hospital NHS Foundation Trust for 2024/2025.

We would like to start by acknowledging the many highlights and achievements delivered by the Trust during the last year.

We make specific reference to Priority 2: Reducing the number of complaints citing poor communication (continued from the last year). We note that the overall number of complaints increased during the past year and welcome the Trust's continued commitment to addressing this issue given poor communication from health services has been identified as a thematic issue in patient surveys.

We previously welcomed the focus through Priority 3 on reducing the number of falls during 2024/25 and now note with concern that despite the focus on this area during the past year there was an increase of 8% in patient falls during the past year. Falls can result in lasting impacts on health, mobility and independence and we hope the Trust will make more progress in this area in the coming year.

We welcome the continued focus on sepsis for the coming year, as well as the introduction of a priority focus area on reduction in violence and abuse towards staff. We note with concern the number of incidents of violence, abuse and challenging behaviour that were reported during the past year and support the Trust's work to ensure that staff can work in a safe and supportive environment.

We note the following areas where improvements have been made;

- The Care Quality Commission's recognition of the improvements made to the Trust's urgent and emergency services, which are now rated as good, following an inspection in April 2024.

- The significant reduction in the number of patients waiting at 52 weeks and above for treatment over the last financial year due to the implementation of various waiting list initiatives and despite a background of record winter pressures and increasing numbers of referrals.

- The provision of multiple avenues for staff to raise concerns, including the Freedom to Speak Up Guardians and Champions, and ensuring confidentiality and protection from detriment

We highlight the following areas of concern and areas for improvement in relation to performance against national indicators;

- The significant increase in cancer referrals and the challenges in addressing and meeting diagnostic and treatment timelines.

- Improvement required in the timeliness of responses to complaints and ensuring that complaints are addressed in accordance with regulatory requirements.

- The feedback from the results of the Trust's Maternity Survey which revealed a number of areas as needing improvement, with the Care Quality Commission describing those areas as 'significantly worse' than the national average.

- The decline in the percentage of patients who would recommend the Trust to their family and friends, down from 93% in 2023/24 to 78% in 2024/5.

The Committee were pleased to see the announcement from the Secretary of State for Health and Social Care in January that plans will go ahead to deliver a new hospital facility at Milton Keynes University Hospital, under the Government's New Hospital Programme and the commencement of the local radiotherapy run by Oxford University Hospital from 2025.

We would like further information in the future illustrating the ways in which patients and the public were involved with the production of the Quality Account.

In conclusion we welcome the opportunity to consider and comment on the report, and we look forward to working constructively with the Trust to support the scrutiny process and our residents.

Cllr Emma Holland-Lindsay, Chair, Central Bedfordshire, Social Care Health and Housing Overview and Scrutiny Committee.

Glossary of Terms and Abbreviations

Abbrev	Name	Description	Context
A & E	Accident & Emergency	hospital department specialising in the acute care of patients who arrive without a prior appointment	NHS
AAAC	Admissions Avoidance and Ambulatory care	generic term for activities aimed at reducing in patient care	
ACS	Ambulatory Care Services	Services provided to an outpatient, where the patient does not need to stay in the hospital.	NHS
AFC	Agenda for Change	NHS project re pay	NHS
AGM	Annual General Meeting	A meeting that is held every year to discuss issues and elect new officials	General
AHP	Allied Healthcare Professional	Generic term for professionals other than doctors and nurses who treat patients, therapists, physios, dieticians etc	NHS
AHSC	Academic Health Science Centre	A partnership between a healthcare provider and one or more universities	NHS
AIMS	Accreditation for Inpatient Mental Health Services	A standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards	
ALE	Auditors Local Evaluation	The Auditors' Local Evaluation (ALE) assesses how well NHS organisations manage and use their financial resources and highlights areas for improvement (from Audit Commission)	NHS
ALOS	Average Length of Stay	The average amount of time patients stay in hospital	NHS
AMM	Annual Members Meeting	A meeting that is held every year to give members the chance to hear about what the trust has done in the past year	NHS
	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.	MKUH
ANP	Advanced Nurse Practitioner	A nurse who has completed a masters' degree in clinical practice, trusted to assess, diagnose, manage and care for patients with complex clinical needs.	NHS
AO	Accountable Officer	A person responsible to report or explain their performance in a given area.	NHS
AOMRC	Association of Medical Royal Colleges	Brings together the expertise of the medical Royal Colleges and Faculties to drive improvement in health and patient care through education, training and quality standards	NHS
AOP	Annual Operating Plan	A plan setting out how the organisation will achieve its aims	NHS

APA	Annual Performance agreements	Clinical Service Unit performance priorities set as part of the Annual Plan.	MKUH
APMS	Alternative Provider Medical Services	These are contracts that can be sought by the private, voluntary and public sectors	NHS
APR	Annual Plan Return	Submission of the annual plan to the regulator	NHS
ARM	Annual Reporting Manual	Monitor's rules on what should be included in the Annual report and accounts	Monitor
ASB	Accounting Standards Board		General
BADS	British Association of Day Surgery	Medical association, identify key performance metrics	NHS
BAF	Board Assurance Framework	Board document to assure the Board that risks to strategic priorities are being managed	NHS
BCM	Business Change Managers	Within IT, working mainly on process change and mapping	MKUH
BGAF	Board Governance Assurance Framework	Sets out the list of risks to the organisation and how they are being mitigated against	NHS
BLS	Basic Life Support	The medical care given to someone with life-threatening injuries before they can be given full medical care in hospital	NHS
BMA	British Medical Association	Trade union and professional body of doctors	NHS
BME	Black and Minority Ethnic	Terminology normally used in the UK to describe people of non-white descent	General
BoD	Board of Directors	Executive Directors and non Executive Directors who have collective responsibility for leading and directing the foundation trust	NHS
CG	Caldicott Guardian	Chief clinician who is held responsible for clinical record keeping (from Caldicott enquiry outcomes)	NHS
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	NHS
CBA	Cost Benefit Analysis	A process for calculating and comparing the costs and benefits of a project.	NHS
CCP	Co-operation and Competition Panel	The Panel helps ensure that the Principles and Rules of Co-operation and Competition for the provision of NHS-funded services support the delivery of high quality care for patients and value for money for taxpayers.	NHS
CCG	Clinical Commissioning Group	Replaced Primary Care Trust. Led by local GPs to commission services	NHS
Cdiff	Clostridium difficile	A bacterial infection that most commonly affects people staying in hospital	NHS
CDU	Clinical Decisions Unit		MKUH

CE/CEO	Chief Executive Officer	Leads the day to day management of the Foundation Trust	NHS
CES	Commissioning Enablement Services		
CF	Cash Flow	The money moving in and out of an organisation	NHS
CGF	Clinical Governance Facilitator	Co-ordinates senior leadership team (doctor, nurse and manager) in new CSUs (replace HCFs.	MKUH
CIP	Cost Improvement Programme	Also known as Transformation programme	MKUH
CMACE	Centre for Maternal and Child Enquiries	Set up to address the relatively high stillbirth and infant mortality rates in the UK	NHS
CoA	Chart of Accounts	A list defining the classes of items against which money can be spent or received.	NHS
	Code Victor	Major Emergency Alert	NHS
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	NHS
	Common Front Door	Area where urgent care and A & E services can be co located	MKUH
CoP	Code of Practice	A set of regulations	NHS
CPA	Care Programme Approach	A particular way of assessing, planning and reviewing someone's mental health care needs.	NHS
CPD	Continuing Professional Development	Continued learning to help professionals maintain their skills and knowledge	NHS
CPN	Community Psychiatric Nurse	A registered nurse with specialist training in mental health	NHS
CQC	Care Quality Commission	Regulator for clinical excellence	NHS
CQUIN	Clinical Quality Incentive Scheme	The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation.	NHS
CRS		IT System	MKUH
CSU	Clinical Service Units	Business units in MK Hospital	MKUH
CTG	Cardiotocography	a technical means of recording the fetus fetal pulse heartbeat	Medical
DANI	Dignity and Nutrition - CQC	CQC outcomes specifically for Dignity and Nutrition	NHS
	Datix	Risk management system	MKUH
DCA	Director of Corporate Affairs	The board member responsible for how the trust interacts with the community it services	NHS
DD	Due Diligence	Is the term used to describe the performance of an investigation of a business or person	General

DGH	District general hospital		NHS
DH/DoH	Department of Health	The ministerial department which leads, shapes and funds health and care in England	General
DNA	Did not Attend	A patient who missed an appointment	NHS
DOC	Doctor on call		NHS
DOCC	Department of Critical Care		MKUH
DoF	Director of Finance	The Board member leading on finance issues in the trust; an executive director	NHS
DOSA	Day of Surgery Admission	When patients are admitted on the day of their surgery rather than the day before	NHS
DPA	Data Protection Act	The law controlling how personal information is used	General
DPH	Director of Public Health	A senior leadership role responsible for the oversight and care of matters relating to public health	NHS
	Delayed Transfer of Care	Patients who are medically fit but have not been discharged	NHS
	Dr Foster	Benchmarking tool to assess relative performance	NHS
	Duty of Candour	Consultation on including a contractual requirement for health providers to report and respond to incidents, apologise for errors etc	NHS
ED	Executive Directors' (meeting)	Semi-formal meeting of Executive Directors on Monday morning and Thursday afternoon	MKUH
EDD	Expected Delivery Dates		Medical
EBITDA	Earnings before interest, taxes, depreciation and amortisation	Measure of an organisation's earnings - used for Foundation Trusts	Finance
EHR	Electronic Health Record	Health information about a patient collected in digital format which can theoretically be shared across different healthcare settings	NHS
	Ejusdem Generis	Latin for "of the same kind," used to interpret loosely written statutes. Where a law lists specific classes of persons or things and then refers to them in general, the general statements only apply to the same kind of persons or things specifically listed. Example: if a law refers to automobiles, trucks, tractors, motorcycles and other motor-powered vehicles, "vehicles" would not include airplanes, since the list was of land-based transportation	General
ENP	Emergency Nurse Practitioner	Specialist A&E nurse	NHS
EOC	Exec on Call		
EPR	Electronic Patient record		MKUH

ESR	Employee Staff Record system	HR system in use	MKUH
FCE	Finished Consultant Episode	unit of measure for counting caseload	NHS
FOI	Freedom of Information	The right to ask any public sector organisation for the recorded information they have on any subject	general
	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	NHS
	Force Majuere	A French term literally translated as "greater force", this clause is included in contracts to remove liability for natural and unavoidable catastrophes that interrupt the expected course of events and restrict participants from fulfilling obligations. Read more: http://www.investopedia.com/terms/f/forcemajeure.asp#ixzz1WcZ76AP5	General
	Francis Report	report into Mid Staffs hospital	NHS
FRC	Financial Reporting Council	The UK's independent regulator responsible for promoting high quality corporate governance and reporting to foster investment	NHS
FReM	Financial Reporting Manual	Issued by HM Treasury	Government
FRR	Financial Risk Rating	Published quarterly by Monitor on the basis on a foundation trust's forward plan and in-year performance against that plan, rated 1-5 (1 is highest risk, 5 is lowest risk)	
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	NHS
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.	General
FTFF	Foundation Trust Financing Facility	Finance house for cheap credit for Foundation Trusts	NHS
FTGA	Foundation Trust Governors' Association	National membership association for governors of NHS foundation trusts	NHS
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	NHS
FY	Financial Year	The year used for accounting purposes, in the UK from 6 April to 5 April	

GDP	Gross Domestic Product	The value of a country's overall output of goods and services	General
GMC	General Medical Council	The independent regulator for doctors in the UK	NHS
GI	Gastrointestinal		NHS
GMS	General Medical Services		
GP	General Practitioner	Doctor who provides family health services in a local community	NHS
	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.	MKUH
GT&FG	Governance Task & Finish Group	Previous governance struture for managing action plans (pre-dates Programme Board and PMO)	MKUH
GUM	Genito-unitary medicine	For sexually transmitted diseases/infections	Medical
HCA	Healthcare Assistant	staff working within a hospital or community setting under the guidance of a qualified healthcare professional	General
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	NHS
	Healthwatch	Local independent health and social care critical friend	NHS
	Healthcare Standard 7	National IT standard to ensure healthcare systems can talk to each other	NHS
HEE	Health Education England	the NHS body responsible for the education, training and personal development of staff	NHS
HES	Hospital Episode Statistics	a national return of activity data that is used for national and local planning	NHS
HCGF	Healthcare Governance Facilitators	Replaced by CGFs after 1 December	MKUH
HR	Human Resources	the department which looks after the workforce of an organisation e.g. Pay, recruitment, dismissal	General
HRG	Healthcare Resource Group	Groupings of interactions to enable tariff application	
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	General
HSDU	Hospital Sterile Decontamination Unit	Part of Clinical Support Services CSU	MKUH
JHSMR	Hospital Standardised Mortality Rate	Number of deaths which is compared with other trusts	NHS

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	General
	Hypoxic	Lack of oxygen	NHS
IAPT	Improved Access to Psychological Therapies	an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Clinical Excellence for treating people with depression and anxiety disorders	NHS
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	NHS
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)	NHS
IBP	Integrated Business Planning		
IG	Information Governance		
IP	Inpatient	a patient who is hospitalised for more than 24 hours	NHS
IT	Information Technology	the study or use of systems(especially computers and telecommunications) for storing, retrieving and sending information	General
JSNA	Joint Strategic Needs Assessment	analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas	General
	Keogh Reviews	Reviews of Hospitals led by Sir Bruce Keogh, originally targeted hospitals with high mortality rates.	NHS
	Kings Fund	independent charity working to improve health and care in England	General
KPIs	Key Performance Indicators	indicators that help an organisation define and measure progress towards a goal	General
LA	NHS Leadership Academy	national body supporting leadership development in health and NHS funded services	NHS
LAT	Local Area Team	Replaced SHA and reports to Commissioning Board	NHS
LD	Learning Disabilities	a disability which affects the way a person understands information and how they communicate	General
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	General
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	General
LOS	Length of Stay	a term commonly used to measure the duration of a single episode of hospitalisation	NHS

M&A	Mergers & Acquisitions	mergers are a joining of two corporate entities of notionally equal stature, acquisitions are take-overs	General
MDP	Maternity Development Plan		MKUH
MEWS	Maternity Early Warning System		
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	General
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	General
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	NHS
MKUH FT	Milton Keynes University Hospital Foundation Trust	Abbreviation of Milton Keynes University Hospital NHS Foundation Trust	MKUH
MKUCS	Milton Keynes Urgent Care Centre	Consortium with GPs (40% owned by Trust) based in the hospital to alleviate A&E	MKUH
MOC	Manager on call		NHS
	Monitor	Regulatory Body "Independent' organisation to monitor foundation trusts	NHS
	Morbidity	the proportion of sickness or of a specific disease in a geographical locality.	General
	Mortality	the relative frequency of deaths in a specific population; death rate.	General
MoU	Memorandum of Understanding		General
MRI	Magnetic Resonance Imaging	a medical imaging technique	NHS
MRSA	Methicillin-Resistant Staphyloccus Aureus	a bacterium responsible for several difficult-to-treat infections in humans	NHS
MSA	Mixed Sex Accommodation	wards with beds for both male and female patients	NHS
MUST	Malnutrition Universal Screening Tool	MUST’ is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other	NHS

		care settings and can be used by all care workers.	
	Mutatis mutandis	with suitable or necessary alterations. (used when comparing events or areas and taking into account obvious differences)	General
NE	Never Event		NHS
NED	Non Executive Director		General
NHS	National Health Service	publicly funded healthcare system with the UK	General
NHSCB	NHS Commissioning Board, now NHS England	the national body with statutory responsibility for commissioning primary care and specialised care, it also authorises and develops CCGs	General
NHS Direct	NHS Direct	24-hour telephone helpline and website providing confidential information on health conditions local healthcare services, self help and support organisations	NHS
NHS England	NHS England	an executive non-departmental public body with a mandate from the Secretary of State to improve health outcomes for people within England	NHS
NHSII	NHS Institute for Innovation and Improvement	now part of NHS England, develops and spreads new work practices, technology and improvements in leadership	NHS
NICU	Neonatal Intensive Care Unit		MKUH
NHSLA	NHS Litigation Authority	Manages Clinical Negligence Scheme for Trusts	NHS
NHSP	NHS Professionals	provides bank (locum)healthcare staff to NHS organisations	NHS
NHSTDA	NHS Trust Development Authority	provide governance and accountability for NHS trusts in England and delivery of the foundation trust pipeline	NHS
NICE	National Institute for Health and Care Excellence	provides national guidance and advice to improve health and social care	General
	Node	Joint leadership team of a clinical unit. Usually comprises a doctor , a nurse and a manager, but with some local variations	MKH
NMC	Nursing and Midwifery Council	nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands	NHS
NPfIT	National Programme for IT	linked to Connecting for Health	NHS
NPSA	National Patient Safety Agency		NHS
NRLS	National Reporting and Learning System	Database for recording patient safety incidents (held by MPSA)	NHS

NSFs	National Service Frameworks	set clear quality requirements for care	NHS
Nuffield Trust	Nuffield Trust	independent source of evidence-based research and policy analysis for improving health care in the UK	NHS
OASI	Obstetric Anal Sphincter Injuries	*to do with vaginal tears (maternity)*	Medical
OBC	Outline Business Case	BC preceeding FBC for large requirements	General
OFR	Operating and Financial Review		NHS
OFT	Office of Fair Trading	the UK's consumer and competition authority, which aims to make markets work well for consumers	General
OBMH	Oxfordshire & Buckinghamshire Mental Health		
OP	Outpatients	a patient who is not hospitalised for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment	NHS
	Orange form	Used to track the 18 week target	
OSCs	Overview and Scrutiny Committees	established in local authorities by the Local Government Act 2000 to develop and review policy and make recommendations to the council	General
OUH	Oxford University Hospital		
PA	Programmed Activities	4 hour blocks that are used to make up a consultant's contract.	NHS
PALS	Patient advice and liaison service	You can talk to PALS who provide confidential advice and support to patients, families and their carers, and can provide information on the NHS and health related matters.	NHS
PbR	Payment by Results or 'tariff'	a way of paying for services that gives a unit price to a procedure	General
PDC	Public Dividend Capital	Public dividend capital represents the Department of Health's equity interest in defined public assets across the NHS. It constitutes an asset of the Consolidated Fund. The department is required to make a return on its net assets, including the assets of NHS trusts, of 3.5 per cent.	NHS
PDD	Planned date of discharge		
PDR	Personal Development Review	Appraisal system	MKUH
PDSA	Plan, do, study, act		General
PEAT	Patient Environment Action Team		

PFI	Private Finance Initiative	a scheme where private finance is sought to supply public sector services over a period of up to 60 years	General
PIP	Performance Improvement Programme	Now superseded by (Financial) Recovery Plan	MKUH
PLACE	Patient-Led Assessments of the Care Environment	local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food cleanliness and general building maintenance	NHS
PLC	Patient Level Costing		NHS
PLCV	Procedures of Limited Clinical Value		
PLiCs	Patient Level Information Costing System	IT system to provide patient level costing	NHS
POA	Pre-operation assessment		
PPH		*relating to maternity care/caesarean section*	MKUH
PCT	Primary Care Trust	a local commissioning body that has now been replaced by CCGs and NHS England LATs	NHS
PPI	Patient and Public Involvement	mechanisms that ensure that members of the community - whether they are service users, patients or those who live nearby - are at the centre of the delivery of health and social care services	NHS
PROM	Patient Reported Outcome Measures		NHS
	Productive Ward	Initiative to streamline operation of wards - included in Maternity Development Plan, due to be rolled out across the hospital	MKUH
	Protected time		
PSR	Patient Safety Requirements	Investments required for patient safety	MKUH
PTS	Patient Transport Services	free transport to and from hospital for non-emergency patients who have a medical need	NHS
PYR	Prior Year		NHS
QA	Quality Assurance	monitoring and checking outputs and feeding back to improve the process and prevent errors	General
QGAF	Quality Governance Assurance Framework	assess the combination of structures and processes in place, both at and below board level, which enable a trust board to assure the quality of care it provides	
QIPP	Quality, Innovation, Productivity and Prevention	12 work streams to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements.	NHS

	Quality Accounts	An annual report to the public from providers of NHS healthcare services about the quality of their services	NHS
QOF	Quality and Outcomes Framework	a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients	NHS
RAG	Red, Amber, Green classifications	a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)	NHS
RCA	Root cause analysis		General
RCGP	Royal College of General Practitioners	professional membership body for GP's	NHS
RCP	Royal College of Physicians	professional membership body for doctors	NHS
RCPSYCH	Royal College of Psychiatrists	professional body responsible for education, training, setting and raising standards in psychiatry	
RCS	Royal College of Surgeons	professional membership organisation representing surgeons	NHS
R&D	Research & Development	developing new products or processes to improve and expand	General
	Red	Projects will be assessed as have an overall risk rating of red where it is considered that the project is not being delivered as planned in respect of progress and/or impact.	MKUH
REID	Risk Evaluation for Investment Decisions by NHS Foundation Trusts	Governance processes for all major investments undertaken by NHS foundation trusts	
RGN	Registered General Nurse	a nurse who is fully qualified and is registered with the nursing and Midwifery Council as fit to practice	NHS
RoI	Return on Investment		General
RTT	Referral to treatment	Used as part of the 18 week indicator	NHS
	Rule 43	Issued by Coroners to organisations. Must be responded to within 56 days. Lord Chancellor's office keep a record of all rule 43s issued	Government
SEMLEP	South East Midlands Local Economic Partnership		
SFI	Standing Financial Instructions	Found on the intranet under 'Trust Policies'	
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology	NHS

SI	Serious incident	A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care	NHS
SID	Senior Independent Director	a non executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair	NHS
SIRG	Serious incident Review Group	to review serious incidents and identify learning points	MUKH
SLM	Service Line Management	A framework for the delivery of clinical services	MKUH
SLA	Service Level Agreement	an agreement between two or more parties	General
SLM/R	Service Line Management/Reporting	a system in which a hospital trust is divided into clinical areas that are then managed, by clinicians, as distinct operational units	NHS
SLR	Service Line Reporting	A reporting system which by comparing income against expenditure gives a statement of profitability at service line level	MKUH
SoCI	Statement of Comprehensive Income	Overall summary showing income and expenditure	Finance
SoC	Strategic Outline Case	First Business Case for large investments	NHS
SoS	Secretary of State	accountable to parliament for delivery of health policy within England, and for performance of the NHS	General
SPA	Single Point of Access	provides a first point of contact for people wishing to access mental health, learning disability, and drug and alcohol recovery service	NHS
SPA	Supporting professional activities	Allowable time for clinicians to undertake professional development, research or medical audit work etc.	NHS
SPERA	Surgical Procedures with Excluded and Restricted Access		
SRR	Significant risk register	Risks scored 15 and over	MKUH
SSA	Same sex accommodation		
	Start up report	Used as a 'PID ' for a programme, and produced by the Programme Manager	MKUH
SUI	Serious Untoward Incident	AKA Serious Incidents	NHS
T&C	Terms and conditions	set the rights and obligations of the contracting parties, when a contract is awarded or entered into	General
TCS	Transforming Community Services	Local programme to implement a national initiative to improve 'field' services	MKUH

TDA	Trust Development Authority	Regulator for Non foundation trusts	Nationa ;
T&O	Trauma & Orthopaedics		
TTO	To Take Out	Medication for patients to take home following discharge	MKUH
	Transition Plan	Outstanding actions from original CQC report - relates to ongoing actions not being monitored or actions the Board decided upon	MKUH
TRR	Trust risk register		MKUH
TTO	To Take Out	Medicines given to discharging patients	
	Vanguard method	Check. Plan. Do	General
VoC	Variation of Conditions	After conditions have been set by CQC they may be removed or varied. If the latter, then these VoCs supersede the original conditions	NHS
VTE	Venous thromboembolism	Blood clotting, usually caused by inactivity. Should be assessed for routinely to ensure care pathways take into risk	NHS
WiC	Walk in Centre	Provided jointly with the hospital and local GPs under a commercial arrangement as the Urgent Care Centre	MKUH
WLI	Waiting List Initiative	Waiting List Initiatives	NHS
	Work package	Sub-component of a project OR a single product project	General
WTE	Whole time employees	Member of staff contracted hours for full time	General
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	