Board of Directors

Public Meeting Agenda

Meeting to be held at 10.00 am on Thursday 5 September 2019 in the Conference Room, Academic Centre, Milton Keynes University Hospital.

Item No.	Title	Purpose	Type and Ref.	Lead
1. Introduction and Administration				
1.1	Apologies	Receive	Verbal	Chairman
1.2	Declarations of Interest • Any new interests to declare • Any interests to declare in relation to open items on the agenda	Noting	Verbal	Chairman
1.3	Minutes of the meeting held in Public on 10 July 2019	Approve	Pages 5-18	Chairman
1.4	Matters Arising/ Action Log	Receive	Pages 19-20	Chairman
2. Chair and Chief Executive Strategic Updates				
2.1	Chairman's Report	Receive and Discuss	Verbal	Chairman
2.2	Chief Executive's Report • CQC inspection report	Receive and discuss	Pages 21-62	Chief Executive
3. Quality				
3.1	Patient Story	Receive and Discuss	Presentation	Director of Patient Care and Chief Nurse
3.2	Nursing staffing update	Receive and Discuss	Pages 63-72	Director of Patient Care and Chief Nurse
3.3	Urgent and Emergency Care Operations – new framework for assessment and reporting in East of England	Receive and Discuss	Pages 73-102	Acting Director of Operations, Medicine
3.4	Mortality Update	Receive and Discuss	Pages 103-114	Medical Director
4. Performance and Finance				
4.1	Performance report Month 4	Receive and Discuss	Pages 115-128	Deputy Chief Executive
4.2	Finance update report Month 4	Receive and Discuss	Pages 129-136	Director of Finance
4.3	Workforce update report Month 4	Receive and Discuss	Pages 137-144	Director of Workforce
5. Assurance and Statutory Items				
5.1	Freedom to Speak Up Board update	Receive and Discuss	Pages 145-152	Director of Workforce/Freedom

Item No.	Title	Purpose	Type and Ref.	Lead
				to Speak Up Guardians
5.2	Board Assurance Framework	Receive and Discuss	Pages 153-162	Director of Corporate Affairs
5.3	Annual Infection Control Report 2018/19	Note	Pages 163-186	Director of Patient Care and Chief Nurse
5.4	Annual Complaints Report 2018/19	Note	Pages 187-208	Director of Patient Care and Chief Nurse
5.5	Annual Report on Safeguarding 2018/19	Note	Pages 209-230	Director of Patient Care and Chief Nurse
5.6	Management Board upward report	Note	Pages 231-234	Chief Executive
5.7	(Summary Report) Finance and Investment Committee – 1 July & 5 August 2019	Note	Pages 235-238	Chair of Committee
5.8	(Summary Report) Workforce and Development Assurance Committee – 5 August 2019	Note	Pages 239-242	Chair of Committee
5.9	(Summary Report) Charitable funds Committee – 1 July 2019	Note	Pages 243-244	Chair of Committee
5.10	(Summary Report) Audit Committee – 16 July 2019	Note	Pages 245-246	Chair of Committee
5.11	(Summary Report) Quality and Clinical Risk Committee – 16 July 2019	Note	Pages 247-249	Chair of Committee
6. Administration and closing				
6.1	Questions from Members of the Public	Receive and Respond	Verbal	Chairman
6.2	Motion to Close the Meeting	Receive	Verbal	Chairman
6.3	Resolution to Exclude the Press and Public	Approve	The Chair to request the Board pass the following resolution to exclude the press and public and move into private session to consider private business: *"That representatives of the press and*	Chairman

Item No.	Title	Purpose	Type and Ref.	Lead
			members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted."	

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in PUBLIC on 10 July 2019 in the Conference Room, Academic Centre, Milton Keynes University Hospital

Present:

Simon Lloyd	Chairman
Joe Harrison	Chief Executive
John Blakesley	Deputy Chief Executive
Andrew Blakeman	Non-executive Director (Chair of Audit Committee)
Parmjit Dhanda	Non-executive Director (Chair of Charitable Funds Committee)
Danielle Petch	Director of Workforce
Nicky McLeod	Non-executive Director
Nicky Burns-Muir	Director of Patient Services and Chief Nurse
Mike Keech	Director of Finance
Ian Reckless	Medical Director
Helen Smart	Non-executive Director (Chair of Quality and Clinical Risk Committee)
Heidi Travis	Non-Executive Director (Chair of Finance & Investment Committee

In attendance:

Kate Jarman	Director of Corporate Affairs
Ian Wilson	Associate Non-Executive Director
Julie Goodman	Trust Lead for Complaints and PALS (item 3.1)
Amit Kalla	Consultant Anaesthetist, Guardian of Safe Working Hours (item 5.2)
Adewale Kadiri	Company Secretary

2019/07/01	**Welcome**
1.0	The Chairman welcomed all present to the meeting.
2019/07/02	**Apologies**
1.2a	Apologies were received from Caroline Hutton, Tony Nolan, and John Clapham
2019/07/03	**Declarations of interest**
1.2b	No new interests had been declared and no interests were declared in relation to the open items on the agenda.
2019/07/04	**Minutes of the meeting held on 3 May 2019**
1.4	The minutes of the public Board meeting held on 3 May 2019 were accepted as an accurate record.

	Helen Smart referred to the issue of pressure ulcers referred to at para 13.4 and asked that context be provided around the actions being taken to resolve them.
2019/07/05	**Matters Arising/ Action Log**
5.1	There were no matters arising in addition to those included on the agenda. The action log was reviewed in turn: <u>362: Nursing staffing report</u> The Chief Nurse reported that the baseline assessment has not yet been completed. It will be presented at the September meeting. <u>363: Finance update month 10</u> The Director of Finance referred to the recent announcement from NHS Improvement regarding non-clinical agency - the Trust will continue to make decisions on agency use based on organisational need. <u>364: Workforce report</u> The flu analysis is still in progress and will be presented at the September meeting
2019/07/06	**Chairman's Report**
6.1	The Chairman confirmed that the CQC inspection process is complete and that their final report would be discussed at the September meeting.
6.2	NHS Improvement are recruiting for the Chair of the East of England Ambulance Service, and the Chairman asked if anyone would be interested in putting themselves forward.
6.3	The Chairman acknowledged the publicity that has surrounded the pensions issues particularly in relation to senior doctors. This has been picked up by governors and will be discussed at their meeting next week.
6.4	The 'topping-off' ceremony at the Cancer Centre went well. BBC Look East were in attendance. The Chairman confirmed that the project remains on track. The Deputy Chief Executive clarified that the technical completion would be at the end of November, and the expectation is that the clinical teams would be able to move in before the end of December, and that patient care would start before Christmas. There will be more certainty by September.
6.5	The Chairman referred to the NHS implementation framework which has now been published, and he remarked about its positivity around culture.
6.6	The Cancer Centre Gala Ball is to be held on Friday 13 September. 220 tickets have been sold so far - 30 more would need to be sold in order to achieve breakeven. Galliford Try is sponsoring the event. Anyone wishing to purchase tickets is asked to contact Vanessa Holmes. **Resolved**: The Board **noted** the Chairman's' Report

2019/07/07	**Patient's Story**
7.1	Julie Goodman attended to deliver the patient's story. The story arose from a complaint that a patient had lodged anonymously on NHS Choices. The communications team noticed it and the complainant was asked to contact the PALS team to discuss her concerns which included lack of confidentiality, poor quality of food and a lack of engagement around discharge. An investigation of the issues raised found that the patient in question had spent 2 days in the OU with no access to hot food, that there were in fact some poor professional conduct issues, and that discharge arrangements had been fragmented. A telephone call was made to the complainant during which an apology was given as well as a promise that issues raised would be addressed.
7.2	A task and finish group was set up to consider the discharge issue. This is an area of focus for the Trust, and there is a desire to engage with patients proactively. It was acknowledged that in this case things were "done to" the patient. Patients should know exactly what to expect, and there is a need for clear documentation to be put in place for this purpose. At present, patients do not always understand what they are being told. A process of welfare checks (which are already in place on ward 24) is to be put in place, whereby checks on patients are carried out a day after discharge. Also, senior sisters will conduct communication rounds in late afternoon in order that patients' families and carers have opportunities to engage with the team. This is to be coordinated with the length of stay project.
7.3	An action plan has been put in place to focus improvement activity. Conversations are to be held with patients and discharge team to see if there have been improvements in what patients experience. The team would like to attend another Board meeting in 6 months to provide feedback on the process. One of the team's aims is to see a reduction in the number of complaints received.
7.4	Nicky McLeod enquired whether the plans generated cover the themes raised in other complaints. In response, Julie Goodman confirmed that they covered most of them, and that issues around discharge and medication delays are also being considered. In response to an additional question about confidentiality, it was noted that the matron had picked this up. The member of staff who had been responsible for the breach on this occasion had come from an agency, and the issue had been taken up with both the member of staff and the agency. The Chief Nurse confirmed that confidentiality is included in the induction for agency staff. The Chief Executive acknowledged that this process did not work on this occasion, but the Trust is clear that if agency staff break the rules, they will not be engaged in future.
7.5	In response to a question as to how the lessons learnt would be shared, the Chief Nurse indicated that some of this activity had already started.
7.6	Parmjit Dhanda cautioned against the danger of over-compensating regarding confidentiality. Julie Goodman confirmed that the Trust already has a good process in place, but that on this occasion none of those systems was followed – it was a one off. **Resolved**: The Board **noted** the patient's story.

2019/05/08	**Chief Executive's update**
8.1	The Chief Executive informed the Board that since the last meeting, there has been some national recognition of the Trust's work on staff benefits – including reference in a speech by Simon Stevens. The Executive Team is working towards the launch of all the first-year priorities – the car parking and pensions initiatives are progressing, with cooperation from the unions. Baroness Harding will be visiting the Trust on 22 July to help launch the schemes. Helen Smart mentioned some positive feedback that she had received, including for the provision of table tennis facilities and gratitude from an anaesthetist for enabling her to take parental leave.
8.2	The Trust has been chosen as one of the organisations to test the new way of managing waiting times for elective care. The NHS nationally is considering how to measure this while encouraging organisations to manage patient care differently. For example, if outpatient appointments can be held virtually, although this would undermine the current measurement system, it is would be the right thing to do.
8.3	The Deputy Chief Executive explained that 2 new measures are being proposed: average wait, which is currently 8.5 weeks for MKUH, and a certain percentage of cases to be cleared within a different time. It is acknowledged that changing the measurement will lead to changes in behaviour, and the Trust will recalculate old indicators to see if relative performance has got better or worse. 12 trusts are involved in this work, while other organisations are involved with the new A&E target. The Chief Executive announced that the Trust is now in the top quartile of performance against the RTT 18-week targets, and it is keen not to lose sight of that. The Board will be kept updated. The trial starts on 1 August and runs until at least January and may continue beyond that. There is a communications workstream to help patients understand the implications of the changes.
8.4	The Trust has received a letter of congratulations from the regional team for achieving 5th position in the country for A&E performance. It was confirmed that the hospital is currently very busy. As time has gone on, the Trust's ability to open escalation areas has reduced. July tends to be the hospital's busiest month by volume, including a big increase in surgical cases, but the winter months are busier by length of stay, including the number of patients staying over 14 days. So far, A&E performance in July has been well above the national average at 94%.
8.5	The Trust received another letter indicating an increased pressure on reporting.
8.6	The Chief Executive announced that it has been agreed that a piece of governance work is to be done within the MK place. The question to be considered is whether some of the layers of bureaucracy could be removed – for example, giving some commissioning responsibilities to providers. Progress on this will be reported in September.
8.7	The Chief Executive noted that the pensions issue is a national story. There has been much media interest and the BMA and Royal Colleges have been heavily involved. At MKUH, to date, although there has been

	some irritation, there has been no impact on patient care. Nevertheless, the Trust is conscious of the issues and remains abreast of the efforts being made nationally to resolve the situation. **Resolved**: The Board **noted** the Chief Executive's Report.
2019/07/09	**Trust objectives**
9.1	The Chief Executive introduced the executive team presentation on the Trust's objectives. He signalled the establishment of a direct line of sight between the objectives and how the Board understands the organisation's progress. The key objectives link to BAF and the Trust strategy, and sets the template of the future management through the Board.
9.2	<u>Objective 1 – Patient safety</u> The Trust is seeking to reduce length of stay by 10%. Steps to be taken to achieve this will include reducing the time taken to prepare medication for patients to take home (TTO), improving the discharge lounge, and effecting more discharges at the weekend. Progress on this will be reported to the Board in September.
9.3	Nicky McLeod made the point that achieving this objective would be dependent on the whole local system and enquired whether other partners have agreed similar objectives. In response, the Chief Executive remarked that the Trust has a leading role in connecting different parts of the system, and there is an awareness externally of what the Trust is seeking to achieve. In any event, there are things over which this organisation has control that it could be doing better. The Medical Director added that the system-wide bed base is under review to ensure that they are appropriately staffed.
9.4	Parmjit Dhanda observed that Milton Keynes has a relatively small stock of community beds and enquired whether consideration is being given to the work on rehabilitation wards and the relationship with other organisations. In response, it was noted that two thirds of the patients whose discharge has been delayed are from MK, and that some of them become stranded as a result of a lack of planning before their admission.
9.5	Regarding 7-day working, the Medical Director explained that there are 10 standards in total of which 4 are priorities, but that NHS Improvement are now paying more attention to the other 6.
9.6	The Medical Director acknowledged the increased bureaucracy around the Getting it Right First Time (GIRFT) process, but it remains helpful. The Trust has already had a number of visits and these have led to conversations internally about why the Trust might be an outlier in a particular area. The Director of Clinical Services is leading on this. There will be metrics and targets attached to the length of stay and 7-day standards, but for GIRFT the focus would be on implementing the recommendations in their reports.
9.7	<u>Objective 2 – patient experience</u> The Director of Corporate Affairs indicated that the patient experience improvement programme would be extended.

	The Deputy Chief Executive stated that a review of patient catering is to be conducted, particularly to ascertain whether the current "cook chill" system provides patients with sufficiently enjoyable and nourishing food. A more detailed assessment is to be presented to the Board in September.
9.8	Regarding the care environment, the Chief Nurse indicated that available data will be used to triangulate feedback from patients. This will include the use of local surveys that would enable the organisation to assess more clearly whether its actions have made a difference. It was acknowledged that the work done in the past has had little impact on patient survey results, and it would therefore be important for the Trust to hold itself to account at regular intervals.
9.9	<u>Objective 3 - Clinical effectiveness</u> The Medical Director explained that the achievement of this objective relies more than others on a few defined projects. For example, there is a stated desire to implement coronary developments in conjunction with Oxford University Hospitals and regulated by the British Cardiovascular Society.
9.10	A paper is to be presented later in this meeting to signal the Trust's positioning for minimally invasive surgery. If implemented, this would have the effect of improving patient experience by reducing length of stay and the risk of complications.
9.11	In relation to clinical audit, the Director of Corporate Affairs stated that the focus would be on capturing and publishing learning derived from audits. It was acknowledged that clinical audit has not previously had sufficient Board visibility. The Chief Executive made the point that the Trust does meet its obligations under the national audit programme.
9.12	<u>Objective 5 - Developing MK at place</u> The Chief Executive highlighted the importance of optimising relationships both with BLMK and with MK at place and explained that there would be more clarity around deliverables once governance arrangements have been agreed.
9.13	<u>Objective 6 - Teaching and Research</u> The Medical Director announced that the Research and Development annual report is to be presented at the Quality and Clinical Risk Committee next week and would be an opportunity to review recent progress.
9.14	The Director of Workforce stated in relation to further development of clinical schools, that the Trust intends to assess whether the success of the University of Buckingham Medical School could be replicated.
9.15	<u>Objective 7 – Well governed and financially viable</u> The Director of Finance indicated that the routine board reporting is to be reviewed to assess its continued fitness for purpose considering the new contract form.
9.16	The Board is required to undertake an independent governance review in accordance with the well led framework. It is planned that this will take place in the autumn and will be linked to delivery of the CQC action plan. A procurement exercise is currently underway.

9.17	Objective 8 – Investing in our people Phase 1 of the staff benefits package is now being delivered. The overall aim of the programme is to strengthen employee value, with a view to helping to improve recruitment and retention.
9.18	The Trust has a clear intention to become more inclusive. It is likely that a national objective in this area will be set out and this will be reflected in the Trust's approach. The Director of Workforce confirmed that the ethnic minority pay gap is incorporated within this objective. The Chief Executive confirmed that the Trust's workforce reflects the diversity of the MK population, with 27% of staff from a BAME background. However, as in other NHS organisations, there is little progression to higher banded jobs.
9.19	Objective 9 - Estate development The Deputy Chief Executive indicated that there are many ongoing projects, and that progress on the major ones will be reported to the Board.
9.20	Objective 10 – Innovation and sustainability It was noted that the wording of this objective had changed. Regarding eCare, a new business case is to be submitted for the delivery of phase C which is expected to do more on improving pathways. MyCare on the other hand is expected to deliver a broad suite of digital transformation tools – including electronic dictation.
9.21	On environmental sustainability, the point was made that if the Trust can halve the number of patients attending, for example, the fracture clinic in person, this would reduce each patient's carbon footprint. However, the organisation is not yet able to re-design all of its services in this way. Nevertheless, the Board stressed the importance of focusing on environmental sustainability.
9.22	Management Board reported objectives These are objectives that, although important, are not on the list of those to be reported to the Board, and they include objectives such as the use of Positive Patient Identification (PPID) in the administration of medication.
9.23	It was confirmed that the objectives would be circulated and published on the Trust website. Board members were asked to feedback shortly as to whether anything else ought to be added to the list. The Chief Executive confirmed that these objectives cover the next 18 months. In response to a question about resourcing, the Director of Finance indicated that colleagues on the Transformation team are working more collaboratively with commissioning colleagues. **Resolved**: The Board **noted** the Trust objectives and **agreed** to the timescales for reporting on progress on meeting them.
2019/07/10	**Nursing Staffing Update**
10.1	The Chief Nurse introduced the routine nursing staffing paper. She informed the Board that all the divisions have commissioned rolling advertisements. Maternity is fully established, with midwifes having joined the Trust from other organisations – many are interested in the Trust's preceptorship programme.

10.2	The Medicine division held a successful open day appointing 20 healthcare assistants and 12 nurses, although there are still many unfilled vacancies. There are a number of workstreams in place to help address the shortage of healthcare assistants. It had been noted that many of them prefer to work night shifts – this would need to be balanced out. There is a need to work better with universities regarding placements.
10.3	The Chief Nurse announced that her new deputy will be joining the Trust from Health Education England where she had helped to develop the nursing associate role.
10.4	It was agreed that Allied Healthcare Professionals will be included in the September paper.
10.5	In response to a question from Helen Smart as to why healthcare assistants leave the organisation, the point was made that in some cases staff leave once they have obtained their care certificates. Going forward, there is a need to develop career pathways for these staff. There are also at times some misunderstanding about what the role entails. **Resolved**: The Board **noted** the nursing staffing report.
2019/07/11	**CNST Maternity Incentive Scheme Action Plan and Sign Off**
11.1	The Chief Nurse introduced this item, reminding the Board that last year, NHS Resolution, which operates an insurance scheme to help Trusts manage their litigation risk, introduced a discount for organisations that were able to demonstrate compliance against a number of standards specifically relating to maternity services. The Trust was able to access this discount last year and received a £300k rebate. Trusts are required to make a board assurance declaration.
11.2	The Trust is meeting all 10 requirements, although three are proving challenging to support: • 2. Maternity service dataset – this contains an enormous amount of evidence, and most trusts, including those with Cerner systems, are having difficulty reporting on it. The Information Team are doing a lot of work to find alternative ways of reporting. • 4. Demonstrating systems for workforce planning – there are robust systems in place, but Obstetrics and Gynaecology trainees report feeling busier and less supported compared to other units. It was noted that there are management issues that are being dealt with. • 8. Bringing together various departments for training - not all the evidence is immediately available.
11.3	It was agreed that the declaration would be brought back to the Chair for checking, after which the Chief Executive will sign it off. **Resolved**: The Board resolved to **approve** the Trust's declaration on the Clinical Negligence Scheme for Trusts maternity incentive scheme – year 2 and **agreed** to delegate checking and signature to the Chair and Chief

	Executive respectively. The Board also **noted** progress against the action plan
2019/07/12	**Performance Report Month 2**
12.1	The Deputy Chief Executive introduced the month 2 performance dashboard. He informed the Board that RTT performance is beginning to dip slightly. He also announced that from August onwards a change will be made to performance reporting. NHS Improvement are expecting the Trust to make significant reductions on the level of delayed transfers of care (this should not exceed 3.5%). The Deputy Chief Executive undertook to revive the narrative element of the report, and to standardise the standard deviations within the process control charts.
12.2	Helen Smart noted that the complaints response rate had fallen to 82.7% and asked how this will be improved. The point was made that the position had been skewed by a few complaints that had taken a long time to resolve, but that underlying performance remains good.
12.3	The Chairman remarked on the deterioration in cancer waiting times. It was confirmed that the Trust met the 62-day target for April and May but is unlikely to do so for June. The urology and gynaecology teams are under significant pressure. The Chief Executive added that some service decisions made by neighbouring trusts are impacting on demand for services here. The Medical Director also referred to delays in PET CT scans provided through Oxford due to a shortage of isotopes.
12.4	Nicky McLeod was surprised that the latest Friends and Family Test feedback dated back to October 2018. The Chief Nurse informed the Board that the Trust has decided to bring the service inhouse and is in the process of recruiting to that role. **Resolved**: The Board **noted** the Month 2 Performance Report.
2019/07/13	**Finance Report Month 2**
13.1	The Director of Finance introduced the month 2 finance report. He informed the Board that at this early point in the year, the Trust is performing in line with or better than control total on a year to date basis. The new contract form is operating effectively. The revenue position reflects the phasing of the contract value.
13.2	The highlights include: • Regarding PSF/ICS – achieving this funding is contingent on the ICS meeting its control total. However, at month 2, there are significant challenges within the system particularly in the commissioning bodies. The position will be monitored in month 3. • The Trust has been notified that it will receive an additional £400K as a result of an audit adjustment at another trust which has led to their PSF allocation being significantly reduced.
13.3	On capital, the Trust has been notified by the region of the need to reduce capital send by 20%. MKUH is working with its ICS partners to consider

	what would be acceptable in the circumstances. Some schemes are already contractually committed which limits the Trust's ability to defer schemes. There is a risk that the capital that the Trust received from the ICS could be lost but the national position is recognised. **Resolved**: The Board **noted** the month 2 Finance Report.
2019/07/14	**Workforce Report Month 2**
14.1	The Director of Workforce presented the month 2 workforce report and highlighted the following: • There was a slight increase in the vacancy rate • The turnover rate and agency spend have remained within target • Sickness absence levels have climbed slightly • Statutory and mandatory training and appraisals performance have remained at target levels.
14.2	It was noted that there is a desire from the centre that regional networks are managed differently.
14.3	Following the suicide of a member of NHS staff under disciplinary action, there is now a requirement to manage cases more tightly. An update will be presented at a future Board meeting. Reports on the staff survey and flu planning will also be presented in September. **Resolved:** The Board **noted** the Month 2 Workforce Report.
2019/05/15	**Risk Management**
15.1	The Director of Corporate Affairs introduced this item. She indicated that a summary of the BAF risks had been presented in this occasion as work is ongoing to update the 2019/20 framework against the Trust objectives. New high scoring risks around admin capacity are to be added – a more detailed conversation around these is to be held at the Quality and Clinical Risk Committee.
15.2	Regarding the Significant Risk Register (SRR), the CQC inspection had raised questions about the Board's visibility of this. This is a large and live document and some risks have already changed. The Risk and Compliance Board meets monthly to moderate its management. The Register has been presented to the Board for discussion, and it will go to the Audit Committee for a review of process. The question was raised as to how regularly the Board would want to see this. The Director of Corporate Affairs also indicated that changes are to be made to the way long running risks are managed.
15.3	Andrew Blakeman made the point that the BAF should be a distillation of key Board risks on the SRR and suggested that this needs to be described more clearly. There was a question whether Board consideration of the SRR represents a good use of its time, but it was acknowledged that when the issue is next raised by regulators, the Trust should be better able to describe its processes. It is also important to establish that the Audit Committee is content with this process.

	Resolved: The Board **noted** the contents of the Board Assurance Framework.
2019/07/16	**Guardian of Safe Working Hours Annual Report**
16.1	The Medical Director introduced this item and welcomed Dr Amit Kalla, the Guardian of Safe Working Hours, to the meeting. There are 160 trainees in the hospital, employed by the Trust under national terms and conditions. Under the current system there has been a move away from hours worked towards a work schedule model, and trainees can report breaches of this schedule via exception reports.
16.2	Dr Kalla informed the Board that he has been the guardian since 2017. He receives exception reports for schedule breaches and rest breaches. He considers that there is a good culture of exception reporting in the Trust. Most of the reports are to do with workload, and a shortage of trainees is also an issue. There has also been a change in culture among consultants. The number of breach reports is now falling but it is unclear whether this is because things are better, or trainees are reluctant to report. Dr Kalla also referred to a number of issues within ENT and surgery that have now been resolved. The Medical Director reflected that it is always a struggle to ensure that feedback is heard. **Resolved:** The Board **noted** the Guardian of safe Working Hours' annual report
2019/07/17	**Medical Revalidation**
17.1	The Medical Director introduced this item. He explained that doctors are required to provide positive feedback from their Responsible Officer every 5 years. This relates to consultants, speciality doctors and to agency doctors. The purpose of this report was to confirm that the Trust has fulfilled its statutory responsibilities in respect of medical appraisal and revalidation for doctors who have a prescribed relationship with the organisation. **Resolved**: The Board **endorses** the approval of the 'statement of compliance' confirming that the Trust, as a designated body, is compliant with the regulations
2019/07/18	**Learning from Gosport**
18.1	The Medical Director presented this paper. By way of background, he informed the Board that Gosport Hospital is a small community hospital in Hampshire, close to Portsmouth. There had been various reports about things that went on there some years ago, and following an investigation by an independent panel, it was found that over 450 patients had died, over an 11 year period, in circumstances where opioid medications had been prescribed and administered without appropriate clinical justification.
18.2	Two of the wider issues emerging from the enquiry and which remain relevant today were around prescribing practices and speaking up. There

	were collective regulatory failures in the initial investigations. At this Trust, there are various measures in place to ensure safe prescribing.
18.3	Andrew Blakeman expressed concern about potential unintended consequences, in that patients might not receive the pain relief that they need. The Medical Director made the point that the issues in Gosport are of little relevance to current practice. The Chief Nurse added that the cultural element raised by the case - that staff can speak up where they observe poor or dangerous practice – is of more relevance. **Resolved**: The Board **noted** the report on learning from Gosport
2019/07/19	**Management Board Upward Report**
19.1	The Chief Executive drew the Board's attention to the report summarising key discussion points at the most recent Management Board meeting. He indicated that the report will evolve as the objectives are picked up.
2019/07/20	**Finance and Investment Committee summary report 29 April and 3 June 2019**
20.1	The Board noted the summary report of the Finance and Investment Committee meetings held on 29 April and 3 June 2019.
2019/07/21	**Workforce Development Assurance Committee summary report 29 April 2019**
21.1	The Board noted the summary report of the Workforce and Development Assurance Committee meeting held on 29 April 2019.
2019/07/22	**Charitable Funds Committee summary report 29 April 2019**
22.1	Parmjit Dhanda informed the Committee that good progress is being made on the Cancer Centre appeal. It is a big target, and the Fundraising Practice will continue to provide support until the end of the year.
2019/07/23	**Use of Trust seal**
23.1	The Director of Corporate Affairs confirmed that the Trust Seal had been used in relation to the settlement of the Pathway Unit stage 2 contract with Galliford Try. The Deputy Chief Executive confirmed that under a P22 contract there is a requirement to sign under seal at each of the 4 stages. **Resolved**: The Board **noted** the use of the Trust Seal.
2019/07/24	**Questions from members of the public**
24.1	A question was raised by a public governor in attendance as to what is being done about the 7.8% Did Not Attend rate. By way of context the Director of Finance indicated that the Trust compares favourably with other providers, some of which have much higher rates. The Director of Corporate Affairs stated that the rate is higher in some specialities than others, but the expectation is that MyCare will improve DNA rates across

	the board. The Trust is also encouraging more patients to receive letters on their phones.
2019/07/25	**Any other business**
25.1	There was no other business.

	All					Action log – All items				
	Public/ Private	**Action item**	**Mtg date**	**Agenda item**		**Action**	**Owner**	**Due date**	**Status**	**Comments/Update**
Board of Directors	Public	362	11 Jan 2019	10.7	Nursing staffing report	The Chief Nurse agreed to carry out a baseline assessment for allied health professional staff	Nicky Burns-Muir	5 Sept 2019	Closing	The baseline assessment is covered within the Nursing Staffing Update
Board of Directors	Public	363	1 Mar 2019	11.2	Finance Update Month 10	The Director of Workforce is to consider, in conjunction with the rest of the executive team, what an aspirational agency target should look like	Danielle Petch	5 Sept 2019	Closing	The aspirational agency target is to be discussed in the private section of the meeting
Board of Directors	Public	364	1 Mar 2019	12.2	Workforce Report	A more granular report on the take up of the flu vaccine in the various parts of the hospital is to be produced	Danielle Petch	5 Sept 2019	Closing	Delivery of the flu campaign in 2019/20 is covered in the Workforce Report

Milton Keynes University Hospital NHS Foundation Trust

Inspection report

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Date of inspection visit: 02 Apr to 09 May 2019
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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Milton Keynes University Hospital NHS Foundation Trust (MKUH) was opened in 1984. It is a single-site trust that operates all clinical services from its main base at Milton Keynes Hospital. MKUH provides services including urgent and emergency care, medical and surgical non-elective services, maternity, as well as children's inpatient and outpatient services to more than 400,000 people in Milton Keynes. In addition, the trust provides a wide range of elective outpatient, day case and elective services. MKUH became a foundation trust in 2007.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good

What this trust does

Milton Keynes University Hospital NHS Foundation Trust provides services including urgent and emergency care to adults and children 24 hours a day, medical and surgical non-elective services, maternity, as well as children's inpatient and outpatient services. In addition, the trust provides a wide range of elective outpatient, day case and elective services.

The trust has 550 beds and employs more than 4,000 staff, the hospital sees and treats approximately 400,000 patients each year comprising of both outpatient and emergency attendances. There are approximately 457 inpatient beds of which 38 are paediatric, 53 are maternity, nine are critical care, and 80 are day case beds. The trust has 12 operating theatres four of which are dedicated for emergency surgery. The trust holds around 389 outpatient clinics per week across most specialities including trauma and orthopaedics, vascular, breast, urology, diabetes and obstetrics.

Patient numbers

Trust activity from February 2018 to January 2019:

•87,460 Urgent and emergency attendances

•68,954 Inpatient admissions

•613,397 outpatient appointments

•923 in patient deaths

•3,434 babies delivered

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Summary of findings

What we inspected and why

We inspected the following acute health services as part of our continual checks on the safety and quality of health care provision:

- Urgent and emergency care
- Surgery
- Medical care including older people's care service
- Maternity

We did not inspect:

- Critical care
- Outpatients
- Diagnostic imaging
- Services for children and young people
- End of life care

These services were last inspected in 2014. Safe for end of life care was last inspected in 2016.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed: Is this organisation well-led?

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

What we found

Overall trust

Our rating of the trust stayed the same. We took into account the current ratings of services not inspected this time. We rated it as good because:

- We rated effective, caring, responsive and well- led as good and safe as requires improvement.
- We rated seven of the trust services as good and one, which was surgery as requires improvement overall.
- We rated well led for the trust as good overall.
- During this inspection, we did not inspect critical care, outpatients diagnostic imaging, services for children and young people or end of life care. The ratings we published following the previous inspections are part of the overall rating awarded to the trust this time

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

Summary of findings

- Urgent and emergency care and surgery were rated as requires improvement. Not all staff had completed mandatory training, prevent and control infection processes were not always followed, emergency equipment was not always checked daily as per trust policy, medicines were not always stored correctly and not all safety results and performance met the expected standard.
- Medical care including older people's care service and maternity services were rated as good on this inspection.
- Critical care, outpatients diagnostic imaging, services for children and young people and end of life care were rated as good at previous inspections

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- Urgent and emergency care, surgery, medical care including older people's care service and maternity services were rated as good on this inspection. The trust provided care and treatment based on national guidance and evidence of its effectiveness, staff assessed and monitored patients regularly to see if they were in pain, staff were competent for their roles, staff understood their roles and responsibilities in relation to consent and under the Mental Health Act (MHA)1983, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).
- Critical care, outpatients diagnostic imaging, services for children and young people and end of life care were rated as good at previous inspections

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Urgent and emergency care, surgery, medical care including older people's care service and maternity services were rated as good on this inspection.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.
- Critical care, outpatients diagnostic imaging, services for children and young people and end of life care were rated as good at previous inspections

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- Urgent and emergency care, surgery, medical care including older people's care service and maternity services were rated as good on this inspection, the trust mostly planned and provided services in a way that met the needs of local people, patients' individual needs were taken into account, the trust treated concerns and complaints seriously, investigated them and learned lessons from them, although some complaints were not always responded to within the time lines of the trust's complaints policy.
- Critical care, outpatients diagnostic imaging, services for children and young people and end of life care were rated as good at previous inspections.

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

Summary of findings

- Surgery, medical care including older people's care service and maternity services were rated as good on this inspection, the trust had managers at all levels with the right skills, the trust collected, analysed, managed, and used information well to support all its activities, they had effective systems for identifying risks, planning to eliminate or reduce them, the trust engaged well with patient, staff and stakeholders.
- Urgent and emergency care was rated as requires improvement because not all managers had undergone formal leadership training, and some did not have the capacity to carry out all aspects of the leadership role, including ensuring patient risk assessments were always completed, not all staff had received the correct level of life support training, some patient risk assessments were not completed and checks of emergency equipment were not always recorded, we did not see evidence of robust action plans to address areas where performance failed to meet expected standards and two concerns raised during the 2016 CQC inspection had not been completely addressed and remained a concern during this inspection. These were, hand hygiene and use of PPE and recording of emergency equipment checks.
- Critical care, outpatients diagnostic imaging, services for children and young people and end of life care were rated as good at previous inspections.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in maternity services and trust wide.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including 8 breaches of legal requirements that the trust must put right. We found 26 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued requirement notices to the trust. Our action related to breaches of 8 legal requirements in urgent and emergency care and surgery core services.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections

Outstanding practice

In the maternity department,

Summary of findings

- Two new smartphone application downloads (apps) for pregnant women had been introduced. The apps enabled women to take more ownership and management of their care on a day-to-day basis.
- In December 2018, the 'Warm Baby Bundle' red hat initiative was rolled out across the maternity service for babies at risk of hypothermia and in extra need of skin-to-skin contact.
- In January 2019, the service began to offer pregnant women, who had uncomplicated pregnancy the option of an outpatient induction of labour. This new service was designed in collaboration with women who had previously used the service.
- In line with 'Better Births' and a series of internal improvement and collaborative programmes, the maternity service had improved care continuity for women and families.
- For more information, see the outstanding practice section of the maternity report.
- An online patient portal was introduced to empower patients to manage their own health care appointments.

In medical care including older people's care service

- There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality.
- The wards ensured that patients were given activities and welcome packs. Staff really promoted independence, enabling them to eat at dinner tables, take part in group activities and made sure older patients were ready for discharge. Staff had access to kitchens where they could, for example, assess patients making cups of tea unassisted.
- The service was supported with social workers and dedicated ward discharge teams, that we observed effective communication and the discharge process being discussed at parts of the patient's journey.

Areas for improvement

Action the trust MUST take to improve

We told the trust that it must take action to comply with regulations in relation to the following regularity breaches:

These actions related to urgent and emergency care core service,

- The service must ensure that immediate life support and paediatric immediate life support training compliance is in line with trust targets. Regulation 12 (2) (c).
- The service must ensure that staff are compliant with hand hygiene and personal protective equipment guidelines. Regulation 12(2) (g).
- The service must ensure that all emergency equipment checks are done in line with trust policy and that there is a system in place for ensuring that this is completed. Regulation 12 (2) (e).
- The service must ensure all patients receive relevant risk assessments, including falls risk assessments, pressure ulcer risk assessments and nutritional risk assessments. Regulation 12 (2) (a) assessing H&S risks, (b) mitigating risk to patients.
- The service must ensure there are governance systems in place which monitor and improve the quality of patient care. The service must ensure there are robust action plans to address areas of noncompliance to audits. This includes local audits and national audits. Reg 17 (1) (2) (a) (b) (c).

These actions related to surgery core service,

Summary of findings

- Ensure that basic life support training for all staff, and safeguarding training compliance for medical staff is in line with trust targets. Regulation 12(2)(c).
- Ensure that controlled drugs are checked, and accurate records maintained in line with trust policy. Regulation 12(2)(g).
- Ensure that staff are compliant with personal protective equipment, safe handling of dirty instrumentation and bare below the elbow's guidelines. Regulation 12(2)(h).

Action the trust SHOULD take to improve.

We told the trust that it should take action to comply with minor breaches that did not justify regulatory action to avoid breaching a legal requirement in future or to improve services:

These actions related to urgent and emergency care core service,

- The service should ensure all audits, including Royal College of Emergency Medicine audits, which do not meet expected standards, have robust action plans which are regularly reviewed to improve compliance.
- The service should ensure all medicines are stored safely and securely and ambient room temperatures and fridge temperatures are monitored, recorded and exceptions are escalated appropriately. Controlled drug checks should be carried out in line with trust policy.
- The service should ensure its leaders have enough dedicated time to monitor the quality of their service, and that staff have access to leadership training at a level appropriate to their role.
- The service should ensure complaints are responded to in a timely manner, and within trust guidelines.
- The service should review and record waiting times for patient is the department, including time waiting to see speciality consultants from referral, and waiting times for triage, and for waiting times to treatment.
- The service should review methods of gaining patient feedback and improve their response rates.
- The service should continue working towards meeting the NHS's Seven Day a Week priority standards.
- The service should provide training to reception staff in the recognition of seriously ill patients presenting with 'red flags'.
- The department should display current waiting times in the major's area waiting room.
- The service should provide training to staff carrying out the streaming role.

These actions related to surgery core service,

- Ensure emergency equipment is checked daily and documented, and easily accessible.
- Ensure fridge temperature and ambient room temperatures are checked daily and documented.
- Ensure staff take appropriate action when a patient's condition had deteriorated following assessment.
- Ensure actions are taken to reduce number of last minute cancellations not resolved within 28 days.
- Ensure local policies for invasive procedures are embedded, and continue working towards national NatSSIP and LocSSIP implementation
- Ensure complaints are monitored and they are investigated and closed in a timely manner.
- Ensure methods of gaining patient feedback are reviewed to improve response rates to Friends and Family tests

These actions relate to maternity core services,

Summary of findings

- Ensure all medical and midwifery staff in maternity are up-to-date with safeguarding adults and children training.
- Ensure checks for legionella in water are monitored and documented
- Ensure emergency equipment is checked daily and documented
- Ensure fridge temperature and ambient room temperatures are checked daily and documented.
- Ensure local policies and guidance are up-to-date
- Ensure there are adequate facilities for partners staying overnight to rest comfortably on the postnatal ward.
- Monitor complaints to ensure they are investigated and closed in a timely manner.

The actions relate to medical care including older people's care service,

- Ensure nursing and medical staff meet the trust's mandatory training target.
- Ensure that complaints are investigated and closed in a timely manner.

These actions relate to the trust well led

- The trust should consider reviewing how actions and lesson learnt following incidents and complaints are documented.
- The trust should provide opportunities for the whole board to review the content of the significant risk register.
- The trust should develop a strategy for how it wishes to progress and promote quality improvement across the trust

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as good because:

- The trust had a relatively stable executive board. Leaders had the experience, capacity, capability and integrity to identify the challenges and took actions to address these. Leaders at every level were visible and approachable.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients and key groups representing the local community. There was a clear vision and high-level strategy in place which was supported by the ten objectives. Monitoring progress against the delivery of the objectives was not clear, we were advised each director was responsible for a number of objectives. We did not see any evidence how and when these were reviewed.
- The trust had a workforce strategy 2018 to 2021 which was aligned to the trust strategy and identified commitment to the workforce race equality standard (WRES).
- The executive team and managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on the trust's shared values. Staff were committed to improving the quality of care and patient experience. Staff felt ownership for the hospital and their services and were proud to work at the trust.

Summary of findings

- The board and other levels of governance in the organisation mostly functioned effectively and interacted with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, were set out. Leaders were clear about their roles and accountabilities.
- The trust had some effective systems for identifying risks, planning to eliminate or reduce them. Performance issues were escalated to the appropriate committees and the board through structures and processes in place.
- The trust generally collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged well with patients, staff, the public and local organisations in order to plan and improve services and collaborated with partner organisations effectively.
- Innovation was taking place. The trust was committed to improving patient care, experience and outcomes. There was participation in audits and research and learning from deaths and serious incidents was shared.

However:

- Whilst there were effective systems in place to report, investigate and learn from incidents, complaints and safeguarding alerts, and improvements were made when needed, not all actions and lessons learnt were clearly documented.
- There was not full oversight of the significant risk register at the trust board, which meant that the board may not be aware of all risks to the service.
- Whilst there were systems and processes for learning and continuous improvement throughout the organisation, a strategy had not been developed, there was lack of clear knowledge of processes of improvement and skills to use them at all levels of the trust.

Use of resources

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Apr 2019	Good ➔➔ Apr 2019	Good ➔➔ Apr 2019	Good ➔➔ Apr 2019	Good ➔➔ Apr 2019	Good ➔➔ Apr 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Milton Keynes Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement ↓ Apr 2019	Requires improvement ↓ Apr 2019
Medical care (including older people's care)	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019
Surgery	Requires improvement ↓ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↓ Apr 2019	Good →← Apr 2019
Critical care	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
Maternity	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019
Services for children and young people	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
End of life care	Good Jul 2016	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
Outpatients	Good Oct 2014	N/A	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
Overall*	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Milton Keynes Hospital

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Key facts and figures

Milton Keynes University Hospital NHS Foundation Trust provides services including urgent and emergency care to adults and children 24 hours a day, medical and surgical non-elective services, maternity, as well as children's inpatient and outpatient services. In addition, the trust provides a wide range of elective outpatient, day case and elective services.

The trust has 550 beds and employs more than 4,000 staff, the hospital sees and treats approximately 400,000 patients each year comprising of both outpatient and emergency attendances. There are approximately 457 inpatient beds of which 38 are paediatric, 53 are maternity, nine are critical care, and 80 are day-case beds. The trust has 12 operating theatres four of which are dedicated for emergency surgery. The trust holds around 389 outpatient clinics per week across most specialities including trauma and orthopaedics, vascular, breast, urology, diabetes and obstetrics.

The total number of staff employed at the hospital as of December 2018 was 3537.

The emergency department had 87,4600 attendances from February 2018 to January 2019 and 613,397 outpatient appointments. For the same period there were 3,434 babies delivered at the trust, 68,954 inpatient admissions and 923 deaths.

During the inspection we spoke with 45 patients and their relatives and 134 members of staff. We attended the trust board meeting, harm review meetings, handovers, held staff focus groups and checked 77 healthcare records and medicine charts.

Summary of services at Milton Keynes Hospital

Good  

At this inspection we inspected urgent and emergency services, surgery, medical care including older people's care service and maternity. We did not inspect critical care, outpatients, diagnostic imaging, services for children and young people or end of life care but we combine the last inspection ratings to give the overall rating for the hospital.

Our rating of services stayed the same. We rated it them as good because:

Summary of findings

- Our rating for safe remained requires improvement because not all staff had completed mandatory training, prevent and control infection processes were not always followed, emergency equipment was not always checked daily as per trust policy, medicines were not always stored correctly and not all safety results and performance met the expected standard.
- Our rating for effective remained good because the service provided care and treatment based on national guidance and evidence of its effectiveness. The trust provided care and treatment based on national guidance and evidence of its effectiveness, staff assessed and monitored patients regularly to see if they were in pain, staff were competent for their roles, staff understood their roles and responsibilities in relation to consent and under the Mental Health Act (MHA)1983, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Women's and babies' nutrition and hydration needs were identified, monitored, and met. There was access to an infant feeding specialist to assist women and babies when needed, and the trust's breastfeeding initiation rate was better than the national average.
- Our rating for caring remained good because staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise patient's distress. Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment.
- Our rating for responsive remained good because patients could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit treat and discharge patients were generally in line with good practice. The trust mostly planned and provided services in a way that met the needs of local people, patients' individual needs were taken into account, the trust treated concerns and complaints seriously, investigated them and learned lessons from them, although some complaints were not always responded to within the time lines of the trust's complaints policy. The maternity service had implemented a process to ensure women and their babies were kept together following obstetric surgery in the recovery area. This has had a positive impact on breast feeding, skin to skin bonding and had been shown to result in a lower rate of admissions to the neonatal unit.
- Our rating for well led remained good because managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The services generally had managers at all levels with the right skills and abilities to run services providing high-quality sustainable care, the trust collected, analysed, managed, and used information well to support all its activities, they had effective systems for identifying risks, planning to eliminate or reduce them, the trust engaged well with patient, staff and stakeholders. Senior leaders were visible and demonstrated commitment. Services had a vision for what they wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. Staff understood and demonstrated the trust's vision and values. There was a culture of continuous learning, improvement and innovation across maternity services and managers encouraged staff to look at different ways to improve their service.

Urgent and emergency services

Requires improvement 

Key facts and figures

The emergency department (ED) at Milton Keynes University Hospital NHS Foundation Trust provides a 24-hour service, seven days a week to the local population. It is a local trauma centre and takes walk in patients and patients who arrive by ambulance.

The ED is divided into separate areas for majors, minors and paediatric patients and each area has its own dedicated waiting room. The majors' area consists of 15 majors' trolley spaces, including two side rooms, a five-trolley resuscitation area, a seven-bedded observation area, a six chair ambulatory observation area and a five trolley rapid assessment hub. There is also a dedicated mental health assessment room. The minors' area has a two-trolley bay, a triage room, and five clinic rooms which can be used for specialities including ophthalmology or ear nose and throat specialists. The paediatric ED has a four-trolley area, a high dependency room and another side room which can be used as a mental health assessment room, and triage and treatment rooms.

Patients present to the department either by walking into the reception area or if arriving by ambulance, through a dedicated ambulance only entrance. From 8am to 10pm, self-presenting patients report to a streaming nurse and register at the reception desk. The streaming nurse can re-direct patients who are deemed clinically suitable, to the nearby urgent care centre or the onsite GP during evening hours, and some patients are advised to go to their own GP. Patients who require an ED assessment are directed to the majors' or minors' waiting areas, depending on clinical symptoms. When there is no streaming nurse available, walk-in patients are seen by a triage nurse who allocates the patient to the appropriate waiting area.

Patients arriving by ambulance are taken either direct to resuscitation, or to the rapid assessment and treatment area (RAT) within majors' ED, depending on clinical need. Patients in RAT are triaged, and then allocated an appropriate place in the ED to wait. Patients taken to resuscitation are appointed a dedicated bay depending on their presenting complaint, for example, there is a stroke resuscitation bay, and a trauma bay. There is also a dedicated paediatric bay with specialist paediatric resuscitation equipment.

During our inspection we spoke with 18 members of staff, eight patients and relatives and reviewed 18 electronic patient records.

The inspection team consisted of one hospital inspector, one mental health inspector, two specialist advisors (a registrar in emergency medicine and a senior nurse from emergency medicine), plus a pharmacy inspector.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

There were breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included:

- Not all staff were compliant with hand hygiene and personal protective equipment guidelines.
- Emergency equipment was not always monitored to ensure it was always available and safe to use in any emergency.
- Not all patients had received an appropriate risk assessment. This included risk of falling, risk of developing pressure ulcers and malnutrition risks.
- Most nurses had not received the required level of life support training appropriate to their role.

- There was insufficient governance and oversight of audit results where expected standards had not been met.

We also found the following concerns:

- People could not always access the service within the statutory timeframes. . There were 203 black breaches reported from January to December 2018.
- Department meetings were separated by staff grade: there were no whole team meetings and there were no joint handovers between medical and nursing staff.
- There was variable performance in a number of national audits relating to patient safety and treatment and in some audits, the service failed to meet any of the national standards. This included for example, the Moderate and acute severe asthma audit, and the Consultant sign-off audit. Action plans did not address all areas of non-compliance.
- Patients were not always reviewed by a consultant within 14 hours of admission, in line with recommendations, and some waiting times for some speciality reviews were not recorded. This included time spent waiting for a psychiatric assessment and time waiting to see a speciality doctor.
- Some audits carried out by the service did not meet expected standards and there were no robust action plans in place to address these quality issues.
- Some issues identified during our previous inspection remained the same during this inspection.

However:

- Staff knew their responsibilities for escalating concerns and reporting incidents.
- Staff understood their responsibilities in protecting people from abuse and knew how to report concerns.
- Patients were prioritised according to their clinical condition.
- Care and treatment was provided based on national guidance and had evidence of its effectiveness.
- Patients had their pain assessed and were provided with pain relief when required.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Patients were positive about the care received. They were included in discussions around care and kept informed of treatment plans.
- Planning for service delivery was made in conjunction with a number of external providers, commissioners and local authorities to meet the needs of local people.
- The department had a vision based on a five-year business plan, which set out the department's requirements, and had been developed with involvement from staff and patient groups.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Is the service safe?

Requires improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement because:

Urgent and emergency services

- While the service provided mandatory training in key skills to all staff, not all staff had completed all the required mandatory training. Following our inspection, updated mandatory training figures showed an overall compliance of 86% for nursing staff and an 94% for medical staff.. Figures for immediate life support training and paediatric immediate life support training were low, at 24% and 8% respectively.
- While the service controlled most infection risks well, not all staff followed the trust hand hygiene or personal protective equipment (PPE) policy. There was no evidence of this impacting on patient care or causing harm. Poor hand hygiene compliance was reported as a concern in our last inspection in 2016, and although most staff were compliant with hand hygiene during this inspection, not all staff followed the trust policy.
- Although the service had suitable premises, and looked after them well, not all equipment was checked in line with trust guidance.
- While systems and procedures were in place to assess, monitor and manage risks to patients, including compliance to sepsis screening and responding to, and escalating deteriorating patients, not all safety results and performance met the expected standard.

However:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had completed safeguarding training to the required level.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service mostly prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and had evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed patients' pain, provided pain relief when required and monitored the effectiveness of pain relief given. Patients told us they received pain relief promptly

Urgent and emergency services

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings Most staff had received an appraisal within the previous 12 months. The ED had recently employed a practice development nurse who had commenced clinical supervision and had robust career plans for each of the ED nurses.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff of different disciplines mostly worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

However:

- Whilst the service monitored the effectiveness of care and treatment and compared local results with those of other services to learn from them, some audit results showed compliance was lower than expected. Action plans did not address all areas of the non- compliance. The department contributed to national audits relating to patient care. There was variable performance in a number of national audits relating to patient safety and treatment
- Although the service did not meet all of the NHS's Seven Day a Week priority standards, there were some plans in place to improve compliance where gaps in service provision had been identified. The service's self-assessment indicated they had met six of the ten clinical standards. Two further priority standards had been partially met.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff understood the need to respect personal, cultural, social and religious needs of patients,
- Staff provided emotional support to patients to minimise their distress. Patients were very happy with the care and support they were receiving.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients told us they did not feel rushed when they were speaking to the doctors and nurses in the department

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The trust mostly planned and provided services in a way that met the needs of local people. Planning for service delivery was made in conjunction with a number of external providers, commissioners and local authorities to meet the needs of local people.
- The service took account of some patients' individual needs. Patients with long term conditions or frequent attenders could be identified and patients with learning difficulties or dementia could be flagged on the electronic register to allow their individual needs to be identified and met.

- The service treated concerns and complaints seriously, investigated them and learned lessons from them, although some complaints were not always responded to within the time lines of the trust's complaints policy.

However:

- While most patients could access the service when they needed it and in a prompt way and most waiting times were better than the England average, some patients waited a long time from arrival to initial treatment, and some patients spent longer than average in the department.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Although most managers at all levels had the right skills and abilities to run the service, not all managers had undergone formal leadership training, and some did not have the capacity to carry out all aspects of the leadership role, including ensuring patient risk assessments were always completed.
- Although the trust had effective systems for identifying most risks, planning to eliminate or reduce them, and coping with both the expected and unexpected, some risks were not mitigated. Not all staff had received the correct level of life support training, some patient risk assessments were not completed and checks of emergency equipment were not always recorded.
- Although the trust used a systematic approach to monitor the quality of its services, there were no robust action plans to address areas where performance failed to meet expected standards. The service failed to create an environment in which excellence in clinical care always flourished.
- While the trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation, two concerns raised during the 2016 CQC inspection had not been completely addressed and remained a concern during this inspection. These were, hand hygiene and use of PPE and recording of emergency equipment checks.

However:

- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The department's vision was based on a five-year business plan.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The culture in ED was to be supportive, open and honest.
- The trust collected, analysed, managed and used information well to support most of its activities, using secure electronic systems with security safeguards. The electronic patient records system was secure. All ED staff had secure access to patient records.
- The trust generally engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively, although response rates to the friends and family test were lower than the England average.

Areas for improvement

We found areas for improvement in this service.

Urgent and emergency services

Action the trust **MUST** take to improve urgent and emergency care services.

We told the trust that it must take action to comply with regulations in relation to the following regularity breaches of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

The service MUST:

- The service must ensure that immediate life support and paediatric immediate life support training compliance is in line with trust targets. Regulation 12 (2) (c).
- The service must ensure that staff are compliant with hand hygiene and personal protective equipment guidelines. Regulation 12(2) (g).
- The service must ensure that all emergency equipment checks are done in line with trust policy and that there is a system in place for ensuring that this is completed. Regulation 12 (2) (e).
- The service must ensure all patients receive relevant risk assessments, including falls risk assessments, pressure ulcer risk assessments and nutritional risk assessments. Regulation 12 (2) (a) assessing H&S risks, (b) mitigating risk to patients.
- The service must ensure there are governance systems in place which monitor and improve the quality of patient care. The service must ensure there are robust action plans to address areas of noncompliance to audits. This includes local audits and national audits. Reg 17 (1) (2) (a) (b) (c).

Action the trust **SHOULD**

We told the trust that it should take action to comply with minor breaches that did not justify regulatory action to avoid breaching a legal requirement in future or to improve services:

The service SHOULD ensure that:

- The service should ensure all audits, including Royal College of Emergency Medicine audits, which do not meet expected standards, have robust action plans which are regularly reviewed to improve compliance.
- The service should ensure all medicines are stored safely and securely and ambient room temperatures and fridge temperatures are monitored, recorded and exceptions are escalated appropriately. Controlled drug checks should be carried out in line with trust policy.
- The service should ensure its leaders have enough dedicated time to monitor the quality of their service, and that staff have access to leadership training at a level appropriate to their role.
- The service should ensure complaints are responded to in a timely manner, and within trust guidelines.
- The service should review and record waiting times for patient in the department, including time waiting to see speciality consultants from referral, and waiting times for triage, and for waiting times to treatment.
- The service should review methods of gaining patient feedback and improve their response rates.
- The service should continue working towards meeting the NHS's Seven Day a Week priority standards.
- The service should provide training to reception staff in the recognition of seriously ill patients presenting with 'red flags'.
- The department should display current waiting times in the major's area waiting room.
- The service should provide training to staff carrying out the streaming role.

Medical care (including older people's care)

Good ➔➔

Key facts and figures

Milton Keynes University Hospital Foundation Trust has 321 medical inpatient beds. The trust provides a full suite of medical care, organised into specialties and clinical service units. This includes support to the A&E department, direct assessment of GP referred patients either on the Medical Assessment Unit or via the Ambulatory Emergency Care Unit. There is also a team of hospital geriatricians with close working arrangements with the community to provide effective older people's care.

(Source: Routine Provider Information Request AC1 – Context acute)

The trust had 29,007 medical admissions from November 2017 to October 2018. Emergency admissions accounted for 12,612 (43.5%), 341 (1.2%) were elective, and the remaining 16,054 (55.3%) were day cases.

Admissions for the top three medical specialties were:

•General medicine: 12,923 admissions

•Clinical haematology: 4,258 admissions

•Gastroenterology: 3,825 admissions

(Source: Hospital Episode Statistics)

Milton Keynes University Hospital NHS Foundation Trust has 321 beds located across 13 wards and units.

Ward/unit	**Speciality**
Ward 1 – 27 beds	**Acute Medical Unit**
Ward 2 – 28 beds	**General Medical**
Ward 3 – 28 beds	**Female General Medical**
Ward 7 – 26 beds	**Stroke unit**
Ward 8 – 25 beds	**Gastroenterology**
Ward 12 – 8 beds	**Escalation area for winter, been extended to May 2019.**
Ward 14 – 24 beds	**General Medical and rehabilitation**
Ward 15 – 28 beds	**Male Respiratory**
Ward 16 – 29 beds	**Female Respiratory**
Ward 17 – 24 beds	**Cardiology and Coronary Care Unit**
Ward 18 – 28 beds	**Frail Elderly**
Ward 19 – 32 beds	**General Medical**
Ward 22 – 22 beds	**Haematology and Oncology**

Medical care (including older people's care)

Endoscopy	
Medical Ambulatory Emergency Care	

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

Before the inspection visit, we reviewed information that we held about this services and information requested from the trust.

During the inspection visit, the inspection team:

•spoke with seven patients. We also spoke with five relatives.

•spoke with the managers, matrons, and clinical lead for the service.

•spoke with 15 other staff members; including doctors, nurses and support staff.

•observed handover and bed meetings as well as department board rounds.

•reviewed 25 patient records to assess the care and treatment provided.

The inspection team included an inspector, a medical consultant and a senior nurse specialist advisors. We also had a pharmacy and mental health inspector for support.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.
- The service had robust systems in place to ensure the safety of patients. this included risk assessments and monitoring of clinical outcomes.
- The service generally had enough nursing staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staff kept appropriate records of patients' care and treatment.
- The service prescribed, gave, recorded and stored medicines well.
- Incidents were managed appropriately.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- The service managed patients' pain effectively and provided or offered pain relief regularly.
- Staff were competent for their roles.
- Staff from different disciplines worked together as a team to benefit patients.

Medical care (including older people's care)

- Staff cared for patients with compassion.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could access the service when they needed it.
- The service had managers with the right skills and abilities to run a service providing high-quality sustainable care.
- Managers across the service promoted a positive culture that supported and valued staff.
- The service used a systematic approach to continually improve the quality of its services.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support most of its activities.
- The service engaged well with patients, staff, the public and local organisations.
- The service was committed to improving services by learning from when things go well and when they go wrong.

However,

- The service provided mandatory training in key skills to all staff, but not all staff had completed it in accordance with the services targets.
- Although the service treated concerns and complaints seriously, they were not always investigated, responded to, and closed in a timely manner.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. Staff kept themselves, equipment and the premises clean and there were control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- The service had robust systems in place to ensure the safety of patients. this included risk assessments and monitoring of clinical outcomes.
- The service generally had enough nursing staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Due to ongoing recruitment issues, some medical wards were short of one registered nurse for both the early and late shifts during our inspection, but we saw effective mitigations were in place. Patients' needs were being met.

Medical care (including older people's care)

- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. Staff spoke positively about the new electronic patient record system and used it well.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Incidents were managed appropriately. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service planned for emergencies and staff understood their roles if one should happen.

However:

- The service provided mandatory training in key skills to all staff, but not all staff had completed it in accordance with the services targets.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Audits were completed to ensure staff followed guidance and progress with implementation of guidance was monitored.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- The service managed patients' pain effectively and provided or offered pain relief regularly.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Medical services contributed in a number of national audits relating to patient safety and treatment.
- Staff were competent for their roles. Most staff had received an appraisal to review work performance, provide support and monitor the effectiveness of the service.
- Staff from different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service provided a seven-day service.
- Staff understood the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and knew how to use these to support patients in their care.

Is the service caring?

Good

Medical care (including older people's care)

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff of all levels introduced themselves and took time to interact in a considerate and sensitive manner. Staff spoke with patients in a respectful way.
- Staff provided emotional support to patients to minimise their distress. Relatives we spoke with said they had felt very well supported, and that communication from both medical and nursing staff had been very open, with clear explanations about their relative's treatment.
- Staff involved patients and those close to them in decisions about their care and treatment. We observed staff involving patients and their relatives during assessments and when taking observations on the ward. If the patient's relative had any questions, staff were able to discuss these at the time.

Is the service responsive?

Good 

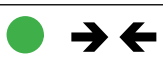
Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided services in a way that met the needs of local people. Services provided reflected the needs of the population served. Services ensured flexibility, choice, and continuity of care where possible. The facilities and premises were appropriate for the services that were delivered at the time of our inspection.
- The service took account of patients' individual needs. The service had an excellent holistic, person centred care approach to meeting the needs of people living with dementia.
- People could access the service when they needed it. Waiting times from treatment and arrangements to admit, treat and discharge patients were in line with good practice.

However,

- Although the service treated concerns and complaints seriously, they were not always investigated, responded to, and closed in a timely manner. Improvements had been made and service leaders were working hard to improve this.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- The service had managers with the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Medical care (including older people's care)

- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support most of its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Outstanding practice

- There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality.
- The wards ensured that patients were given activities and welcome packs. Staff really promoted independence, enabling them to eat at dinner tables, take part in group activities and made sure older patients were ready for discharge. Staff had access to kitchens where they could, for example, assess patients making cups of tea unassisted.
- The service was supported with social workers and dedicated ward discharge teams, that we observed effective communication and the discharge process being discussed at parts of the patient's journey.

Areas for improvement

The trust SHOULD take action to:

- Ensure nursing and medical staff meet the trust's mandatory training target.
- Ensure that complaints are investigated and closed in a timely manner.

Surgery

Good

Key facts and figures

Milton Keynes University Hospital NHS Foundation Trust provides both an emergency surgical service for adults and children over the age of two, as well as a range of elective surgical services for all the main surgical sub-specialties including orthopaedics, general surgery, urology, and ENT.

Surgery services are managed within the trust's surgery division, which is led by a divisional director, general manager, and head of nursing. The division is split into five clinical service units (CSUs), head and neck, anaesthetics, musculoskeletal, theatres and outpatients, and general surgery. There are clinical leads and operational managers for each CSU.

Milton Keynes Hospital has 12 main operating theatres across two phases, four in phase one and eight in phase two. Phase one theatres are dedicated for emergency trauma operations, phase two theatres are dedicated for elective, and day case surgery. Each theatre phase has a post operation recovery area. The hospital has four inpatient wards (20, 21, 23, and 24) with a total of 120 surgical beds, an ambulatory emergency care unit (AECU) and a treatment centre. The treatment centre combined an admissions area with a pre-assessment unit, same day admissions unit and day surgery unit. Fracture and orthopaedic clinics were held at the hospital.

Milton Keynes Hospital provided a range of elective (planned) and emergency (unplanned) surgery services for the community it serves. The trust had 17,278 surgical admissions from November 2017 to October 2018. Emergency admissions accounted for 4,974 (28.8%), 9,958 (57.6%) were day case, and the remaining 2,346 (13.6%) were elective.

During our announced inspection on 2 to 4 April 2019 we visited all areas providing surgery services at the hospital, spoke with 10 patients or their relatives, observed patient care and treatment and looked at nine patient care records. We spoke with 53 members of staff, including nurses, doctors, surgeons, therapists, healthcare assistants, administrators, theatre staff, ward managers, matrons and senior managers. We also considered the environment and held focus groups attended by trust staff prior to the inspection and reviewed the trust's surgery performance data.

The inspection team consisted of a lead inspector, a second inspector, and two specialist advisors (a junior doctor in general surgery and theatre nurse). We were also supported by a mental health inspector and a specialist advisor for medicines management.

Surgery was previously inspected in October 2014 and was rated good for safe, effective, caring and responsive, and outstanding for well-led. The overall rating was good.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it.
- The service had suitable premises and equipment was generally looked after well.
- Although there was a high number of vacancies for nursing and medical staff, the service ensured enough nursing and medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment were on each shift.

Surgery

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers assessed staff compliance with guidance and identified areas for improvement.
- The service was working towards being a seven-day service.
- Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery and as appropriate for individuals.
- Staff understood their roles and responsibilities in relation to consent and under the Mental Health Act (MHA)1983, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff provided emotional support to patients to minimise their distress. Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment.
- Patients could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit treat and discharge patients were generally in line with good practice. From January 2018 to December 2018, the trust's average referral to treatment time for admitted surgical patients was 72.2% within 18 weeks which was above the England average of 68.3%.
- From November 2017 to October 2018, the average length of stay for patients having elective surgery at Milton Keynes Hospital was 2.6 days, which was shorter than the England average of 3.9 days.
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Senior leaders were visible and demonstrated commitment.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. Staff understood and demonstrated the trust's vision and values.
- The service engaged well with patients and staff to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research, and innovation.

However:

- The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it, with attendance at some life support courses being significantly lower than the trust target.
- Medicines were not always stored correctly, and we were not assured that effective governance arrangements were in place to ensure controlled medicines were recorded correctly.

Surgery

- Systems and processes were in place to prevent and control infection, but they were not always followed. The service monitored staff adherence to most infection prevention and control procedures through audits although actions were not always taken to address lack of adherence.
- While policies and guidelines were readily available, staff asked were not aware of any changes to some guidelines, and staff awareness of national guidance varied. Knowledge of guidance varied by level of staff, with band 5 and 6 nurses unaware of NICE guidance.
- The service monitored the effectiveness of care and treatment but did not always use the findings to improve them. The trust participated in nation audits for example the National Emergency Laparotomy Audit and Patient Reported Outcome Measures and while outcomes were variable, the trust generally performed similar to the England average.
- Over the two-year period from 2016 to 2018, the percentage of last-minute surgical cancellations at the trust where the patient was not treated within 28 days was consistently higher (worse than) than the England average.
- Complaints were not always responded to in line with the trust's complaints policy.
- The service did not always have a fully embedded systematic approach to continually monitor the quality of its services. The service used a systematic approach to improve the quality of its services and safeguarding high standards of care.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it, with attendance at some life support courses being significantly lower than the trust target.
- Compliance rates for all levels of children's and adults safeguarding training was below the trust target for medical staff.
- Systems and processes were in place to prevent and control infection but they were not always followed. While the service monitored staff adherence to most infection prevention and control procedures, actions were not always taken to address lack of adherence.
- Emergency equipment was not always checked daily as per trust policy, and resuscitation trolleys were not always easily accessible.
- Medicines were not always stored correctly, and we were not assured that effective governance arrangements were in place to ensure controlled medicines were recorded correctly.
- Although staff assessed risks to patients and monitored their safety, so they were supported to stay safe and assessments were in place to alert staff when a patient's condition deteriorated, actions were not always taken to improve the patient's condition
- Staff understanding and awareness of duty of candour was variable. Staff were unfamiliar with the terminology used to describe their responsibilities regarding the duty of candour regulation, and not all staff said they would discuss any concerns with the patient or provide a full apology.

However:

Surgery

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it.
- The service had suitable premises and equipment was generally looked after well.
- Although there was a high number of vacancies for nursing and medical staff, the service ensured enough nursing and medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment were on each shift.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service prescribed and gave medicines well. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers assessed staff compliance with guidance and identified areas for improvement.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made dietary adjustments for patients' religious, cultural, and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service was working towards being a seven-day service.
- Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery and as appropriate for individuals.
- Staff understood their roles and responsibilities in relation to consent and under the Mental Health Act (MHA)1983, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

Surgery

- While policies and guidelines were readily available, staff asked were not aware of any changes to some guidelines, and staff awareness of national guidance varied. Knowledge of guidance varied by level of staff, with band 5 and 6 nurses unaware of NICE guidance.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. Measures were mainly negative, however trust performance was the same as national average for most outcomes.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

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

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The service understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through the planning, design and delivery of services.
- Patients' individual needs were taken into account. The service had a person-centred care approach to meeting the needs of patients living with a dementia.
- Patients could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit treat and discharge patients were generally in line with good practice. From January 2018 to December 2018, the trust's average referral to treatment time for admitted surgical patients was 72.2% within 18 weeks which was above the England average of 68.3%.
- From November 2017 to October 2018, the average length of stay for patients having elective surgery at Milton Keynes Hospital was 2.6 days, which was shorted than the England average of 3.9 days.
- Concerns and complaints were taken seriously, investigated and learned lessons from the results and shared with all staff.

However:

- Over the two-year period from 2016 to 2018, the percentage of last-minute surgical cancellations at the trust where the patient was not treated within 28 days was consistently higher (worse than) than the England average.
- Complaints were not always responded to in line with the trust's complaints policy.

Surgery

Is the service well-led?

Good

Our rating of well-led went down. We rated it as good because:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Senior leaders were visible and demonstrated commitment.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, however there was limited involvement from staff and patients during development.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients and staff to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research, and innovation.

However:

- The service did not always have a fully embedded systematic approach to continually monitor the quality of its services. The service used a systematic approach to improve the quality of its services and safeguarding high standards of care.
- Response rates historically to the friends and family test were low. The response rate for surgery at Milton Keynes Hospital was 16.9%, which was worse than the England average of 24.0% from January to December 2018. However, there was an improvement in the response rate which was 35% in February 2019.

Areas for improvement

We found areas for improvement in this service.

Action the service MUST take to improve

- Ensure that basic life support training for all staff, and safeguarding training compliance for medical staff is in line with trust targets. Regulation 12(2)(c).
- Ensure that controlled drugs are checked, and accurate records maintained in line with trust policy. Regulation 12(2)(g).
- Ensure that staff are compliant with personal protective equipment, safe handling of dirty instrumentation and bare below the elbow's guidelines. Regulation 12(2)(h).

Action the service SHOULD take to improve

- Ensure emergency equipment is checked daily and documented, and easily accessible.

Surgery

- Ensure fridge temperature and ambient room temperatures are checked daily and documented.
- Ensure staff take appropriate action when a patient's condition had deteriorated following assessment.
- Ensure actions are taken to reduce number of last minute cancellations not resolved within 28 days.
- Ensure local policies for invasive procedures are embedded, and continue working towards national NatSSIP and LocSSIP implementation
- Ensure complaints are monitored and they are investigated and closed in a timely manner.
- Ensure methods of gaining patient feedback are reviewed to improve response rates to Friends and Family tests.

Maternity

Good

Key facts and figures

Milton Keynes University Hospital provides a full antenatal, intrapartum, and postnatal maternity service for the population of Milton Keynes. Some very high-risk mothers are transferred during pregnancy to local specialist centres.

Maternity services are managed through the trust's women's health clinical service unit, which fell under the women and children's division. The current leadership structure includes a divisional medical director, a general manager and a head of midwifery. A clinical director, matrons, operations manager and patient pathway manager also support the senior leadership team.

Milton Keynes Hospital has 53 maternity beds. Of these, 11 delivery rooms are located within the labour ward, including two rooms with birthing pools and one bereavement suite (butterfly suite). Fourteen beds are located on ward 10 (antenatal ward) and the remaining 28 beds are located on ward 9 (postnatal ward). There was also an antenatal day assessment unit (ADAU) and an early pregnancy assessment unit (EPAU), which was not open at night. The service also includes a delivery theatre in the main theatre suite, outpatient antenatal clinics, and provides community-based midwifery services. Community midwives provided care for women and their babies both during the antenatal and postnatal period. They also provide a home birth service.

From October 2017 to September 2018 there were 3,523 deliveries at the trust.

At the last focused inspection in July 2016, we inspected the service in the key questions of safe and well led. We did not inspect, or therefore rate, the service for effectiveness, caring and responsiveness. We rated safety and well-led as good.

Previous to the focused inspection, we carried out a comprehensive inspection in October 2014, where we rated all five key questions (safe, effective, caring, responsive, well led) as good. We previously inspected maternity jointly with the gynaecology service, so we cannot compare our new ratings with previous ratings.

We carried out an announced inspection of the maternity service on 2 to 4 April 2019. We visited clinical areas in the service including the delivery suite, triage area, bereavement suite, antenatal ward, postnatal ward, antenatal clinic, antenatal day assessment unit, early pregnancy assessment unit, theatres and recovery.

We spoke with 15 women and their relatives, and 48 members of staff, including hospital midwives, community midwives, specialist midwives, consultants, anaesthetists, senior managers, student midwives and support staff. We observed care and treatment and reviewed 10 patient care records and 15 prescription charts. We also reviewed the trust's performance data.

The inspection team consisted of a lead inspector, a second inspector, and a specialist advisor (head of midwifery). We also received support from a mental health inspector and a specialist advisor with expertise in medicines management.

Summary of this service

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

Maternity

- There was a strong, visible patient centred culture. Staff were highly motivated and cared for women and babies with compassion, dignity and respect. Women felt involved in their care and were given informed choice of where to give birth. Staff of all disciplines worked together as a team to benefit patients.
- The maternity service worked closely with commissioners and other stakeholders to plan delivery of care and treatment for the local population. This collaborative working ensured future planning covered recommendations laid out by NHS England and the Department of Health.
- The service took account of women's individual needs, including those who were in vulnerable circumstances or had complex needs. Bereavement care provision was in place to support families from their initial loss, throughout their time in hospital and return home.
- Appropriate systems were in place to assess risk, recognise and respond to deteriorating women and babies within the service. Systems were in place to appropriately assess and manage women with mental health concerns.
- Since our last inspection, the service had implemented a process to ensure women and their babies were kept together following obstetric surgery in the recovery area. This has had a positive impact on breast feeding, skin to skin bonding and had been shown to result in a lower rate of admissions to the neonatal unit.
- The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment. Staff monitored its effectiveness and used the findings to improve practice and the care provided.
- Women's and babies' nutrition and hydration needs were identified, monitored, and met. There was access to an infant feeding specialist to assist women and babies when needed, and the trust's breastfeeding initiation rate was better than the national average.
- Staff understood their responsibilities to raise concerns and report patient safety incidents. There was an effective governance and risk management framework in place to ensure incidents were investigated and reviewed in a timely way. Learning from incidents was shared with staff and changes were made to delivery of care because of lessons learned.
- The service made sure staff were competent for their roles. Mandatory and role specific training in key skills was provided to all staff and the service made sure most staff completed it. Staff were encouraged to develop their knowledge, skills and practice.
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. There was strong local leadership within maternity services and staff spoke positively about their senior management team and ward managers.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- There was a culture of continuous learning, improvement and innovation across maternity services and managers encouraged staff to look at different ways to improve their service.

However:

- Although staff understood how to protect patients from abuse and the service worked well with other agencies to do so, not all medical and midwifery staff in maternity had up-to-date safeguarding adults and children training. Compliance for adults and children safeguarding training was variable and slightly below the trust target of 90% in some areas.
- There were some gaps in the flushing logs where there was no evidence that taps had been run to ensure legionella was not present in water

Maternity

- The processes in place to ensure emergency equipment was checked daily, was not always adhered to by staff.
- Fridge temperature and ambient room temperatures were not always documented.
- While the service provided care and treatment based on current-evidence based guidance and quality standard, some policies and guidance had expired their review date.
- We saw there were limited facilities for partners staying overnight to rest comfortably on the postnatal ward. This was raised as a concern at the Maternity Voices Partnership (MVP) group and the service were planning on taking some action to improve provisions for partners.
- The service took longer than the trust target to investigate and close complaints.

Is the service safe?

Good 

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure most staff completed it. The trust target of 90% completion was met for the majority of mandatory training courses.
- The service provided maternity specific training in key skills to staff and made sure most staff completed it. This included an annual protected three-day maternity specific training programme for midwives, and also multidisciplinary 'skills and drills' emergency training for medical and midwifery staff.
- The service generally controlled infection risk well. Staff kept themselves, equipment and the premises clean. Staff had received training on infection prevention and control.
- The premises and environment were generally appropriate to keep women and their babies safe. Whilst the service had a joint recovery area for women having obstetric related surgery, mitigating actions had been taken to reduce this risk.
- Systems and procedures were in place to assess, monitor and manage risks. Patients received assessments, treatment and observations in a timely manner. Staff kept clear records and asked for support where necessary.
- Staffing levels were sometimes lower than planned, however, the service used bank and agency staff to fill gaps, where possible. Staffing levels were regularly reviewed and staff were redeployed within the unit when needed, to keep patients safe from avoidable harm and to provide the right care and treatment. Women received one-to-one care whilst in labour.
- The maternity service monitored the midwife to birth ratio monthly and this was reported on the maternity dashboard. The midwife to birth ratio at our last inspection was 1:30. During this inspection, we found this had improved and was 1:28.
- Medical staffing levels within the maternity service were generally sufficient to keep women and babies safe from avoidable harm and abuse and to provide the right care and treatment. Staffing skill mix levels were generally in line with the England average.
- Staff kept appropriate records of patients' care and treatment. There were systems in place to flag records when women had particular needs. Records were clear, up-to-date and available to all staff providing care.

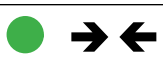
Maternity

- The service followed best practice when prescribing, giving, and recording medicines. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff reported recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service had not completed the national maternity safety thermometer. However, an appropriate range of safety information was being monitored by the service.
- The service planned for emergencies and staff understood their roles if one should happen.

However:

- Although staff understood how to protect patients from abuse and the service worked well with other agencies to do so, not all medical and midwifery staff in maternity had up-to-date safeguarding adults and children training. Compliance for adults and children safeguarding training was variable and slightly below the trust target of 90% in some areas.
- There were some gaps in the flushing logs where there was no evidence that taps had been run to ensure legionella was not present in water
- The processes in place to ensure emergency equipment was checked daily, was not always adhered to by staff.
- Fridge temperature and ambient room temperatures were not always documented.

Is the service effective?

Good 

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service reviewed the effectiveness of care. Local and national audits were completed, and actions were taken to improve care and treatment when indicated.
- Women's and babies' nutrition and hydration needs were identified, monitored and met.
- There was access to an infant feeding specialist to assist women and babies when needed, and the trust's breast-feeding initiation rate was better than the national average.
- Pain was assessed and managed on an individual basis and was regularly monitored by maternity staff.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Results were generally within the expected range when compared with other hospitals, and in line with the national average.
- The service made sure staff were competent for their roles. Staff were encouraged and supported to develop their knowledge, skills and practice. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Appraisal compliance was 93.6%, which met the trust target of 90%.
- Maternity services were committed to working collaboratively. Medical staff, midwives, anaesthetists and other health care professionals supported each other to provide good care.

Maternity

- Women had access to midwifery, obstetric and anaesthetic support seven days a week. Arrangements were in place to keep women and their babies safe out-of-hours.
- People who used maternity services were supported to live healthier lives and manage their own health, care and wellbeing.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked capacity to make decisions about their care.

However:

- While the service provided care and treatment based on current-evidence based guidance and quality standard, some policies and guidance had expired their review date.

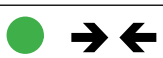
Is the service caring?

Good 

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Staff cared for women and babies with compassion and they were motivated to provide care that promoted women's privacy and dignity. Feedback from women and relatives confirmed staff treated them well and with kindness. Women, their birthing partners and families told us they were very happy with the care and support they received and feedback was consistently positive throughout the inspection.
- Staff took the time, where possible, to interact with women and those close to them in a respectful and considerate manner. Staff were encouraging, sensitive and supportive to women and those close to them.
- Staff provided emotional support to women and their families to minimise their distress. Women's emotional and social needs were as important to staff as women's physical needs.
- Bereavement policies and pathways were in place to support parents in the event of a pregnancy loss, such as miscarriage, stillbirth or neonatal death. The maternity service had a specialist bereavement midwife who had a passion for supporting bereaved families and fellow colleagues. The service supported families from their initial loss, throughout their time in hospital, and on their return home. In addition, bereaved mothers were provided with ongoing support with subsequent pregnancies.
- There was ongoing assessment of women's mental health during the antenatal and postnatal period. The maternity service had access to perinatal mental health specialists, provided by another trust, who provided additional care, support and treatment for women with mental health concerns as needed.
- Staff involved women and those close to them in decisions about their care and treatment. They provided women and their partners the opportunity to ask questions and raise concerns throughout the care pathway.

Is the service responsive?

Good 

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

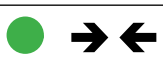
Maternity

- The service planned and delivered in a way that met the needs of local people.
- The importance of choice and continuity of care was reflected in future maternity care provision. The service worked closely with local commissioners and neighbouring trusts to ensure future planning covered recommendations laid out by NHS England and the Department of Health.
- The service worked closely with local stakeholders and neighbouring trusts to establish the Bedfordshire, Luton, and Milton Keynes (BLMK) local maternity system (LMS) to improve maternal and neonatal safety across the clinical network.
- Women were given an informed choice about where they gave birth, in conjunction with consideration of their potential risk. Midwifery-led models of care were offered at the time of our inspection and we saw the service had plans in place to develop a midwife-led unit (MLU) by mid-2019.
- The service had implemented a process to ensure women and their babies were kept together following obstetric surgery in the recovery area, which was an improvement from our last inspection. This has had a positive impact on breast feeding, skin to skin bonding and had been shown to result in a lower rate of admission to the neonatal unit.
- The maternity service took account of women's individual needs, including those who were in vulnerable circumstances or had complex needs. Bereavement care provision was in place to support families from their initial loss, throughout their time in hospital and return home.
- Following feedback from women, the service recently began to offer pregnant women, who had uncomplicated pregnancy and who were fit and well, to have the option of an outpatient induction of labour. This meant that, after attending the hospital to be induced, women could go home for up to 24 hours if they wished.
- A dedicated home birth service came into operation towards the end of 2016. This gave women and their families a fundamental choice in how and where their baby was delivered.
- Women could generally access the right care at the right time. Access to care was managed to take account of women's needs, including those with urgent needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared them with staff. There were processes in place for responding to complaints and information was available to women and their families of how to complain.

However:

- We saw there were limited facilities for partners staying overnight to rest comfortably on the postnatal ward. This was raised as a concern at the Maternity Voices Partnership (MVP) group and the service were planning on taking some action to improve provisions for partners.
- The service took longer than the trust target to investigate and close complaints.

Is the service well-led?

Good 

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. There was strong local leadership within maternity services and staff spoke positively about their senior management team and ward managers.

Maternity

- The trust provided development programmes for staff, which supported them to develop leadership and management skills. Courses were available for first line managers, middle managers and senior managers.
- Maternity services had a clear vision and values which focused on providing a safe and caring service. This mirrored the trust's values of a hospital committed to learning and providing the best possible care and experience for every patient, every time.
- Plans were in place for a midwifery led unit (MLU), and senior leaders were aiming for this to be functioning by mid-2019. Both midwives and senior medical staff told us that it would benefit women to have a midwifery led unit and increase patient safety.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were committed to improving the quality of care and patient experience. Throughout our inspection, we observed a strong patient-centred culture across maternity services.
- The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care. The arrangements for governance were clear and operated effectively. Staff understood their roles and accountabilities.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. People's views and experiences were gathered and acted on to shape and improve the services and culture. We saw evidence that service user feedback was sought to inform changes and improvements to service provision.
- There were positive and collaborative relationships with external partners and stakeholders to build a shared understanding of challenges within maternity and the needs of the local population, and delivery of services to meet those needs. The service was working collaboratively with service users, neighbouring trusts and commissioners via the local maternity system (LMS), to ensure national recommendations for maternity care were implemented across the region.
- Using the national Getting it Right First Time (GIRFT) agenda, the trust was working collaboratively with its neighbouring hospitals and engaging with the national teams to understand where better care could be delivered, learning from best practice nationally and spreading innovation as appropriate.
- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. There was a culture of continuous learning, improvement and innovation across maternity services and managers encouraged staff to look at different ways to improve their service.

Outstanding practice

- Two new smartphone application downloads (apps) for pregnant women had recently been introduced; including one for gestational diabetes (monitoring blood sugars) and one for hypertension (monitoring blood pressure). The apps enabled women to remotely monitor and record tests themselves at home with results sent directly to the antenatal assessment unit where a midwife analysed them, and called the woman if necessary. The apps enabled women to take more ownership and management of their care on a day-to-day basis.

- An online patient portal was introduced to empower patients to manage their own health care appointments. The portal revolutionised the way patients interacted with the service, which supported better care and experience for patients. The technology allowed patients with outpatient appointments to make, cancel or change an appointment over their phone or laptop; and receive appointment letters via the app. The app had won a national award and Milton Keynes Hospital was the first NHS hospital to enable patients to directly manage their appointments online.
- In December 2018, the 'Warm Baby Bundle' red hat initiative was rolled out across the maternity service. The new initiative focused on newborn babies who, due to various factors, would be considered to be at risk of hypothermia, and therefore in extra need of skin-to-skin contact. These babies would be given a red hat, so they could be easily identified to staff as needing additional measures in their care when leaving the labour ward to the maternity ward. The aim of the initiative was to keep mums and babies together, and to prevent avoidable admissions of term babies to the neonatal unit. Avoiding separation meant that women were better able to nurture close and loving relationships with their babies, and to get feeding off to a good start. Following the introduction of the red hats scheme, term admissions to the neonatal unit had reduced significantly.
- In January 2019, following feedback from women, the service began to offer pregnant women, who had uncomplicated pregnancy and who were fit and well, to have the option of an outpatient induction of labour. This meant that, after attending the hospital to be induced, women could go home for up to 24 hours if they wished. The aim of the service was to allow women to feel more relaxed in the comfort of their own home and reduce the time they would have to spend in hospital. This new service was designed in collaboration with women who had previously used the service.
- In line with 'Better Births' and a series of internal improvement and collaborative programmes, the maternity service had improved care continuity for women and families. A new community case-loading team was in place to support women throughout their pregnancy. Plans for further community case-loading teams were in place, including developing teams for women who have had a previous caesarean section.

Areas for improvement

The service should:

- Ensure all medical and midwifery staff in maternity are up-to-date with safeguarding adults and children training.
- Ensure checks for legionella in water are monitored and documented
- Ensure emergency equipment is checked daily and documented
- Ensure fridge temperature and ambient room temperatures are checked daily and documented.
- Ensure local policies and guidance are up-to-date
- Ensure there are adequate facilities for partners staying overnight to rest comfortably on the postnatal ward.
- Monitor complaints to ensure they are investigated

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Bernadette Hanney, Head of Hospital Inspections chaired this inspection and Julie Fraser, Inspection Manager led it. An executive reviewer, supported our inspection of well-led for the trust overall.

The team included nine inspectors, one assistant inspector, one executive reviewer and ten specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

Meeting title	Board of Directors			**Date:** 5 September 2019			
Report title:	Nursing Staffing Report			**Agenda item: 3.2**			
Lead director **Report author Sponsor(s)**	**Name:** Nicky Burns-Muir **Name:** Matthew Sandham			**Title:** Director of Patient Care/Chief Nurse **Title:** Associate Chief Nurse			
FoI status:							
Report summary							
Purpose *(tick one box only)*	**Information**	x	**Approval**		**To note**	x	**Decision**
Recommendation	That the Board receive the Nursing Staffing Report.						

Strategic objectives links	Objective 1 - Improve patient safety. Objective 2 - Improve patient care.
Board Assurance Framework links	Inadequate staffing are contributory issues for BAF risks 1.1 and 1.4.
CQC outcome/ regulation links	Outcome 13 staffing.
Identified risks and risk management actions	
Resource implications	Unfilled posts have to be covered by Bank or agency staff, with agency staff having a resource implication.
Legal implications including equality and diversity assessment	None as a result of this report.

Report history	To every Public Board
Next steps	
Appendices	Appendices 1 and 2

Board of Directors Report on Nursing and Midwifery staffing levels Amalgamated report for June 2019 and July 2019

1. Purpose

To provide Board with:-

- An overview of Nursing and Midwifery staffing levels.
- An overview of the Nursing and Midwifery vacancies and recruitment
- activity.
- Update the Board on controls on nursing spend.

Are we safe ?

2. Planned versus actual staffing and CHPPD (Care Hours per Patient Day)

We continue to report monthly staffing data to 'UNIFY' and to update the Trust Board on the monthly staffing position.

CHPPD is calculated by taking the actual hours worked divided by the number of patients on the Ward at midnight.

CHPPD = hours of care delivered by Nurses and HCSW
Numbers of patients on the Ward at midnight

CHPPD	Total Patient Numbers	Registered Midwives/Nurses	Care Staff	Overall
June	14619	4.8	3.1	7.9
July	14961	4.8	3.2	8.0

Hospital Monthly Average Fill Rates for June and July 2019

Month	RN/RM Day % Fill Rate	HCA/MCA Day % Fill Rate	RN/RM Night % Fill Rate	HCA/MCA Night % Fill Rate
June	82.1%	103.4%	99.2%	126.9%
July	81.6%	102.7%	99.2%	132.1%

- *Ward breakdown of fill rates for June and July 2019 is included in Appendix 1.*

Areas with notable fill rates

Department of Critical Care continues to have a high CHPPD due to low number of patients admitted in June and July.

3. Recruitment

All divisions have rolling adverts out on the NHS job site and are in the process of agreeing open recruitment days for this financial year 2019/20.

- Medicine Division

  The Division have a planned recruitment day on 20th September primarily focused on recruitment for the new Cancer Centre. Medicine will be interviewing in early September following the closure of a Band 5 advert on the 28/08/2019.

  The Chief Nurse has asked the Division to do undertake a dynamic piece of work on Ward 16 to develop a model of care delivery that meets the needs of the patients and delivers on high quality outcomes that address patient safety, effectiveness and patient experience measures. Mapping a new model into the current establishment with the inclusion of Therapies, Pharmacy and Support Services. This will be reported on in the next staffing paper.

  In collaboration with Pharmacy the Medicine division are planning to pilot pharmacy assistants to support and promote medicine safety and management across assessment areas. The principle will be for these roles is to improve medication safety for the areas and improve patient knowledge and understanding of their medications and in preparation for discharge. The additional benefit will be to release nursing time back to patients in the clinical areas.

- Surgical Division

  The Division has taken lessons learnt from their last recruitment event held for Ward 20 and are planning a full recruitment day for Theatres on the 23rd September. They are interviewing Band 5 posts in September following the closure of a Band 5 advert on the 02/09/2019.

  The event for Ward 20 was for the first time supported by expert patients and proved to be hugely beneficial with one gentleman writing to the Chief Nurse expressing his gratitude for being included and he has now agreed to support our expert patient user group going forward.

- Women's and Children Division

  Maternity reported separately in Board paper. Children's continue to have a proactive recruitment campaign and have recruitment events planned for September and October 2019.

Qualified Staff Vacancies

Division	WTE vacancies now	% vacancy now	Post recruited to	Residual WTE vacancy	Residual % vacancy
Women's & Children	26.2wte	14%	18.6wte	7.6wte	8%
Medicine	91wte	24%	33.4wte	57.6wte	16%
Surgery	31wte	16%	15.8wte	16.1wte	8.5%

Total vacancy rate for qualified nurses' including new staff in post approx. ***15.0%***

HealthCare Assistant Vacancies

Division	WTE vacancies now	% vacancy now	Post recruited to	Residual WTE vacancy	Residual % vacancy
Women's & Children	4.12wte	3%	4.12wte	0wte	0%
Medicine	38.66wte	24%	25.8wte	12.9wte	6%
Surgery	13.67wte	13%	5.6	9.07wte	7.5%

Total Trust vacancy rate for HCA's including new staff in post approx. **6%**

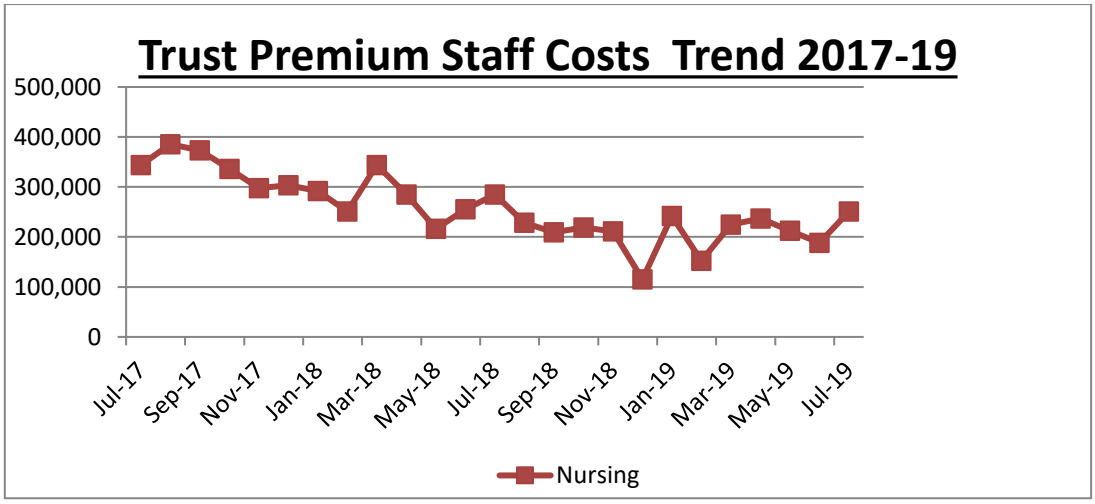
- Please note that these figures are dynamic and so are changing on a daily basis – and recruited to posts will still be subject to leavers. The vacancies need to be validated against vacancies recorded on Electronic Staff Record (ESR) to ensure factual accuracy.

Within these figures the areas with the highest vacancy factor are – Wards 14 and 15. These wards are monitored and supported by the Head of Nursing.

Are we efficient ?

4. Controlling Premium Cost

Agency nursing expenditure continues to stabilise with a small peak in July due to escalation beds being opened on Day Surgery Unit, Wards 3a, 7 and 19.



4.1 Retention

Retention of staff is a key issue for the NHS and is a crucial factor in securing a skilled and sustainable workforce for the future. In addressing the challenges of workforce supply, MKUH is not only focusing on recruitment but also ensure new and existing staff are being supported and encouraged to remain at MKUH.

In Month 4 as reported in the Workforce Board report Nursing and Midwifery turnover rate is 6.9 % with the National average being 11%. This is a further improvement on previous months and has been due the work carried out as part of the NHSi Retention action plan.

4.2 Sickness

Sickness of staff is one of the main factors that contributes to the requirement for temporary staff for the Trust. The Divisions work collaboratively and proactively with their Human Resources Business Partners HRBP's to ensure sickness management policies are adhered too. Month 4 Workforce Board report recorded registered Nursing and Midwifery sickness to be 2.15 % against the Trust target of 4%

Are we effective ?

5. Maternity

Midwifery staffing is planned in line with the national recommendation for safe staffing, which is one midwife to every 28 births. The service is currently funded to provide this level of staff and we use them effectively to follow women throughout their pregnancy to birth and the postnatal period.

Vacancies have been rising since the start of 2019 due to staff retirement, moving location and to gain an improved work life balance.

An active recruitment campaign is now coming to fruition and has seen the following recruitment in June and July 2019:

Maternity	WTE vacancies now	% vacancy now	Post recruited to	Residual WTE vacancy	Residual % vacancy
Midwives	21.2wte	15%	18.6wte	2.6wte	2%

This recruitment is broken down as follows:

- Band 7 = 1.8 WTE Labour Ward Coordinators
- Band 7 = 0.8 WTE Practice Development Midwife
- Band 6 = 4.8 WTE
- Band 5 = 11.2 WTE Preceptorship Midwives

The maternity department believe that MKUH is becoming the maternity unit of choice to work at with recent staff recruited from surrounding hospitals and within the region.

Reasons for seeking employment at MKUH have been stated as flexible working, staff benefits, development opportunities and a friendly atmosphere.

6. Therapies

Therapy vacancies and recruitment activity estimated vacancies in July 2019 are:

Therapies	WTE vacancies now	% vacancy now	Post recruited to	Residual WTE vacancy	Residual % vacancy
Dietetics	0wte	0%	0wte	0	0%
Occupational Therapy	3wte	7.4%	2wte	1wte	2.4%
Speech and Language Therapy	0wte	0%	0wte	0	0%
Physiotherapy	3.8wte	5%	3..8wte	0wte	3%

Occupational Therapists are challenging to recruit and currently with the vacancy factor the resilience is reduced when managing sickness and annual leave commitments.

The inpatient Therapy Service Lead attend the recent job fair in Milton Keynes in August to raise awareness of these roles and opportunities at MKUH. Therapies are working in collaboration with recruitment to initiate rolling bank adverts for all Band 3, 5 and 6 posts.

National there is an increased focus and expectation that all therapy staff will have job plans in place by 2020. A job planning steering group has been formed to oversee the timeline for this initiative and updates will be reported to Workforce Board. Therapies have

agreed that all Band 7 leads will have a completed job plan by the end of August 2019. Further to this the plans are for therapy staff to move across to the health roster which will allow increased transparency for daily therapy staff across the organisation.

Therapies have a workforce planning meeting scheduled in September to review the benchmarking data and analysis to contribute to the development of the Trust Therapies Workforce Strategy.

From September 2019 Therapies will be reporting Care Hours Per Patient Day (CHPPD) for wards 1,2, 7, 14 and 18 as mandated by the changes on reporting of CHPPD requested from the Department of Health.

We celebrate

7. Announcements

- Senior Sister Emma Thorne Ward 21 has been successfully appointed as the new Workforce Matron and will be commencing her post on the 13th September 2019.
- The Practice Development Team have been shortlisted for a Nursing Times Award for their outstanding work on preceptorship. The team will be attending the awards ceremony on the 25th September 2019.
- Congratulation to Stefania Lucia who has been offered one of the first national places on the Florence Nightingale Scholarship Programme or Nursing Associates.
- We successfully bid for monies from Health Education England to support 8 Advanced Clinical Practitioner MSc courses to. development of a cohort across Emergency Department and medicine assessment areas. This is in collaboration with Northampton University and will be reported to board in the next staffing paper.

Appendix 1

Fill rates for Nursing, Midwifery and Care Staff June 2019

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	81.4%	116.0%	101.1%	127.8%	665	5.4	2.8	8.3
MAU 2	79.7%	105.2%	103.3%	139.3%	791	3.6	2.9	6.6
Phoenix Unit	81.4%	90.4%	98.9%	105.0%	673	3.2	3.1	6.4
Ward 15	84.0%	102.6%	100.1%	133.3%	825	3.5	2.7	6.2
Ward 16	81.8%	107.3%	99.2%	134.9%	863	3.4	2.7	6.1
Ward 17	77.4%	97.9%	100.0%	138.3%	746	4.3	2.4	6.7
Ward 18	95.2%	97.4%	100.0%	134.4%	813	3.5	3.8	7.3
Ward 19	79.8%	104.7%	106.7%	143.3%	835	3.1	3.9	7.0
Ward 20	84.4%	121.2%	99.4%	128.6%	738	4.0	3.2	7.3
Ward 21	82.9%	122.3%	100.0%	163.3%	685	3.8	3.2	7.0
Ward 22	82.9%	121.4%	101.1%	150.0%	637	3.8	3.3	7.1
Ward 23	83.6%	125.4%	100.9%	141.3%	1062	3.6	4.8	8.4
Ward 24	91.2%	88.5%	101.1%	-	495	4.8	1.0	5.8
Ward 3	84.6%	90.1%	100.0%	108.8%	833	3.2	3.2	6.4
Ward 5	80.8%	163.2%	129.7%	125.4%	560	7.2	2.1	9.3
Ward 7	76.8%	94.3%	101.4%	124.4%	686	3.6	4.3	7.9
Ward 8	72.5%	101.8%	100.2%	108.3%	738	3.2	2.8	6.1
DOCC	72.5%	100.8%	88.6%	-	166	27.2	1.9	29.1
Labour Ward								
Ward 9	76.8%	85.3%	92.6%	89.6%	1124	2.3	1.8	4.1
Ward 10	81.3%	-	87.3%	-	230	5.6	0.0	5.6
NNU	73.9%	86.0%	92.0%	94.5%	454	8.7	1.6	10.2

Appendix 1

Fill rates for Nursing, Midwifery and Care Staff July 2019

Ward Name	Day		Night		Care Hours Per Patient Day (CHPPD)			
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
AMU	79.7%	120.2%	101.7%	150.0%	715	5.3	3.0	8.3
MAU 2	81.5%	114.0%	103.3%	165.4%	841	3.6	3.2	6.8
Phoenix Unit	85.0%	88.8%	98.9%	103.2%	725	3.2	3.0	6.2
Ward 15	82.8%	107.7%	100.1%	154.8%	865	3.5	2.9	6.4
Ward 16	87.3%	99.0%	98.9%	125.8%	875	3.6	2.5	6.1
Ward 17	75.2%	121.4%	98.8%	156.6%	763	4.2	2.9	7.1
Ward 18	85.4%	103.1%	98.8%	144.1%	848	3.1	4.0	7.1
Ward 19	75.5%	101.0%	97.8%	136.9%	887	2.9	3.7	6.5
Ward 20	84.3%	92.4%	104.4%	108.5%	767	4.1	2.6	6.7
Ward 21	81.3%	108.6%	100.0%	133.9%	733	3.6	2.6	6.3
Ward 22	84.9%	111.6%	100.0%	138.6%	658	3.9	3.0	6.9
Ward 23	84.7%	144.9%	100.0%	152.2%	1111	3.7	5.3	9.0
Ward 24	85.2%	85.2%	99.2%	-	523	4.4	0.9	5.3
Ward 3	84.9%	84.8%	100.0%	119.2%	861	3.2	3.2	6.4
Ward 5	77.1%	150.6%	125.2%	203.8%	501	8.1	2.8	10.9
Ward 7	85.3%	85.6%	116.1%	129.3%	716	4.2	4.0	8.3
Ward 8	74.4%	93.6%	100.0%	112.9%	759	3.3	2.7	6.1
DOCC	72.3%	92.4%	89.2%	-	187	25.2	2.2	27.4
Labour Ward								
Ward 9	77.3%	83.0%	85.9%	95.1%	1073	2.5	1.9	4.4
Ward 10	79.2%	-	82.3%	-	259	4.9	0.0	4.9
NNU	76.4%	75.4%	88.7%	104.8%	294	14.5	2.5	17.0

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 5 September 2019
Report title:	Performance Management Framework in relation to Urgent and Emergency Care (East of England)	Agenda item: 3.3
Lead director Report author Sponsor(s)	Name: Dr Ian Reckless Name: Dr Ian Reckless Name: Prof Joe Harrison	Title: Medical Director Title: Medical Director Title: CEO
FoI status:	Disclosable	

Report summary	In recent months there has been correspondence between the NHSE/I East of England Regional Office and Acute Provider Trusts on the topic of system expectations / measurement / reporting in relation to Urgent and Emergency Care. A benchmarking report has also been shared which the region intends to utilise going forward.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Trust Board is invited to note the correspondence between the Region and MKUH, the revised performance and monitoring framework and the areas of success / challenge as they apply to MKUH.			

Report history	This material has previously been considered by Executive Directors.
Next steps	
Appendices	1. Letter from Ann Radmore, Regional Director to Trusts (05 July 2019) 2. Response of Trust to Ann Radmore's letter (23 July 2019) 3. Urgent and Emergency Care Operations: East of England Acute Trust Categories & Reporting

Sent via e-mail

NHS England and NHS Improvement
East of England

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5 July 2019

To: Acute Trust CEOs

Dear Colleague,

I wrote to all CEOs on 30 April to describe the position on ED performance across the region and nationally. It remains of significant concern and is not currently showing the improvement we, all want to see **(Appendix 1).** I know you feel this too, but we must not normalise this performance – it is not where we need to be and in some Trusts it means over quarter of their patients are waiting over 4 hours.

Thank you for sharing your system plans to reduce demand for A&Es service which as I previously highlighted has been significantly higher compared to the same period last year. However, the pressures have not abated in most places and there remain key areas witin Trusts which are not working optimally. We therefore need to press on demand and accelerate improvement other areas as well - in particular;

- GP streaming -
- Same day emergency care (SDEC)
- Counting and coding issues
- Seven Day service/Weekend discharges
- Reducing Long length of stay

GP Streaming

GP streaming was rolled out across the Region in September 2018. There is significant variation in the volumes of patients going through the service ranging from 32% of A&E attendances at Luton & Dunstable (32%) to <1% at Basildon & Thurrock and North West Anglia. We know that systems have adopted varying models, clinical criteria and some systems have placed greater emphasis on extending GP access out of hours and at weekends.

We have supported several systems to conduct clinical audits to review streaming models and identify opportunities to increase utilisation where possible and especially where performance is most challenged.

The audits identified some key issues ranging from lack of GPs, lack of consistent teams and therefore low confidence in both ED and GP streaming staff, and in some cases triaging and not streaming models were in place. My team are available to support you with the clinical audits where that would be helpful.

Whilst I acknowledge that there is no yet a proven direct relationship between volumes of patients streamed and A&E performance, this is a robust initiative which clearly impacts on patient experience and requires urgent board attention for all trusts whose average "Minors" performance is below 95% (see **Appendix 2** below).

Action:

- You now need to produce a robust plan addressing the challenges highlighted above including shift fill rate for GPs and any other important local challenges identified from local clinical audits. Please submit to the team here trajectories of improvement for increasing the % of patients streamed and achievement of >98% "Minors" performance.

Seven Day Services / Weekend discharges

Weekend discharges are around 33% lower compared to Monday and Friday's average and that this has a significant impact on Monday performance, a situation made even worse by the increases in attendances we are currently experiencing. (**Appendix 2**).

Increasing weekend discharges requires effective seven (7) day working in both in-hospital services and out-of-hospital health and social care services. Some of the key challenges to increasing discharges over the weekend include planned senior medical review, completion of TTA & discharge letters and recruitment to reablement roles especially in rural areas.

I am aware that your systems are fully engaged with the BCF programme as the mechanism for joint 24/7 working to improve the flow of people through the system and across the interface between health and social care. I am also aware of the excellent initiatives that have been successfully rolled out by some of our systems including 7/7 reablement services, Social workers at front door of acute hospitals 7/7 and launch of admission prevention services such as the 7/7 Norwich Escalation Avoidance Team (NEAT). We now need to consider how we further build on this work and at pace. Nationally we are waiting BCF guidance (due to be released shortly) to support continuation of the close working between health and social partners.

In the meantime, I anticipate that your systems are fully engaged and looking to make a head start with the Aging Well programme objectives including greater MDT support for care homes and plans towards achieving the new national standard of urgent crisis response within 2 hours and a timeline of referral within 2 days to reablement.
NHSE/I have hosted several events for systems to show case some of their excellent work and will continue to do that where a need is identified.

All our systems now have the ability to determine care home bed capacity digitally to via a Care Home Bed Capacity Tracker. However, there is lack of clarity about how effective the tool has been (**Appendix 5**)

Actions:

- Ensure a coherent whole system write up – one plan – to achieve 7-day discharges and share with us.
- Confirm to my team what plans and funding are in place or have been agreed to continue and, where necessary increase capacity.
- Plans must also identify the "system agreed" maximum number of Health and Social DToC and accompanied by trajectories of improvement towards that number. Plans should deliver <3.5% DToC.

- Review use of the care home bed tracker and identify if it is giving the expected benefits. Identify how to increase to 75% the percentage of care homes that are actively utilising.

Same Day Emergency Care (SDEC)

Same Day Emergency Care (SDEC) has two key ambitions for 19/20;

- Ensure 100% of trusts are providing SDEC (12 hours day 7 days week) by September 2019 and to deliver 30% of non-elective admissions going via SDEC by March 2020
- Ensure 100% of trusts are providing a frailty service (70 hours a week) by December 2019.

As a region we have made an excellent start to SDEC with five (5) of our trusts are already meeting SDEC opening hours. Three (3) trusts are meeting the 30% non-elective admissions treated via SDEC ambition, with a further eight trusts above 20% (2018 data). Key challenges for SDEC include staffing and finance.

We are supporting six (6) of our trusts with funding participation on the Accelerator training programme to help speed up delivery of SDEC. The programme is due to commence in July 19). In addition, NHSE/I will work with the remaining trusts to support workshops to share learning from the Accelerator Programme. We are also working closely with the national team, to develop clear guidance as to the counting and recording SDEC activity. You will be aware of work the national SDEC survey for which you have been invited to participate. The survey focuses on the types of SDEC offered (e.g. medical/surgical), referral routes and counting mechanisms. A return is due back on 12 July.

Action:

- Please submit trajectories of how your system will deliver objectives 1 & 2 above. The trajectories must be underpinned by robust plans addressing any financial & workforce challenges and any other important local challenges identified locally.

Reducing Long Length of Stay

In 18/19 there was a national ambition to reduce the number of long length of stay (LLoS) beds by 25%. By March 19, the East region had reduced from 1641 LLoS beds (March 18 baseline) to 1323 LLoS beds, a reduction of 19%.

The 19/20 national ambition is to reduce long length of stay beds by 40% (against the March 2018 baseline). I am aware that systems developed plans and improvement trajectories against this ambition in April 19 and that these were signed off at the respective A&E Delivery Boards and I am pleased to say that as a region we are on track against our 19/20 trajectory although some progress at individual system level has been more uneven (**Appendix 3**).

We are working closely with ECIST to support systems to deliver against these plans, based on the ECIST Reducing Long Length of Stay Methodology and Discharge patient tracking list (DPTL). Elliot has written previously to detail the process being followed and highlight the urgency of this work in terms of making sure we have clear visibility of the constraints causing patient delays and inform the support provided to systems.

You will be aware that NHSE/I are running several webinars to support systems as well and that a LLoS event is planned for September 2019.

Actions:

- Trusts are asked to ensure that DPTL data submission roll out has been brought forward to 4th July to provide visibility of the constraints causing patient delays and inform the support provided to systems.
- Please confirm that your system on track to deliver the agreed LLoS reduction trajectory. The trajectory must be underpinned by a robust recovery plan where performance is off track.

Counting and coding

As patient pathways change and new services such as Urgent treatment centres (UTCs), GP Hubs are established, and Walk-in centres are phased out, there is need to ensure counting and coding of activity is accurate and consistent.

The national monthly A&E SitRep guidance is being revised to clarify accurate recording of Type 1 and Type 3 activity as well as GP streamed activity and Same Day Emergency Care (SDEC).
A key challenge delaying this work is the inadequate IT support and lack of digital capabilities. NHSE are working closely with NHSD to implement Digital changes necessary.

Action:

- Systems are asked to think together about who is based place in your STP to support and expedite this work where possible, this will help ensure a true understanding of patent flows in your system.

As always, I would like to thank you and your teams for the continued hard work to run and improve the services we run.

Yours sincerely

Ann Radmore
Regional Director (East of England)

Appendix 1

Overall A&E performance remains challenged and has deteriorated when compared to same period last year.

England and Region performance has been adjusted for the CRS sites	18-19 YTD May-18	Mar-19	Apr-19	May-19		19-20 YTD May-19	YTD 19/20 vs YTD 18/19
Provider perspective							
ENGLAND	**89.6%**	**86.7%**	**85.3%**	**86.6%**		**86.0%**	↓
East Of England	**89.0%**	**83.9%**	**83.3%**	**85.7%**		**84.5%**	↓
East and North Hertfordshire Trust	87.7%	81.0%	80.5%	81.6%		81.1%	↓
The Princess Alexandra Hospital	74.8%	72.2%	69.6%	74.0%		71.8%	↓
West Hertfordshire Hospitals Trust	86.8%	77.1%	81.2%	79.9%		80.5%	↓
Bedford Hospital	91.7%	83.3%	81.7%	81.9%		81.8%	↓
Luton and Dunstable FT (CRS trial site)							
Milton Keynes Hospital FT	95.2%	92.2%	93.4%	93.0%		93.2%	↓
Cambridge University Hospitals FT (CRS trial site)							
North West Anglia FT	83.6%	75.2%	76.7%	79.2%		78.0%	↓
Basildon and Thurrock University Hospitals FT	87.7%	95.7%	92.9%	95.3%		94.1%	↑
Mid Essex Hospital	86.1%	78.6%	77.3%	77.9%		77.6%	↓
Southend University Hospital FT	92.4%	82.7%	82.7%	89.7%		86.2%	↓
James Paget University Hospitals FT	90.4%	83.7%	86.4%	90.1%		88.3%	↓
Norfolk and Norwich University Hospitals FT	84.3%	67.8%	62.2%	74.6%		68.6%	↓
The Queen Elizabeth Hospital, King's Lynn FT	82.0%	82.0%	84.7%	83.8%		84.2%	↑
East Suffolk & North Essex FT (from 01/07/18)	96.6%	92.7%	89.4%	91.3%		90.3%	↓
West Suffolk FT (CRS trial site)							

Source: SDCS A&E SITREP

Weekly Briefing 28/06/2019

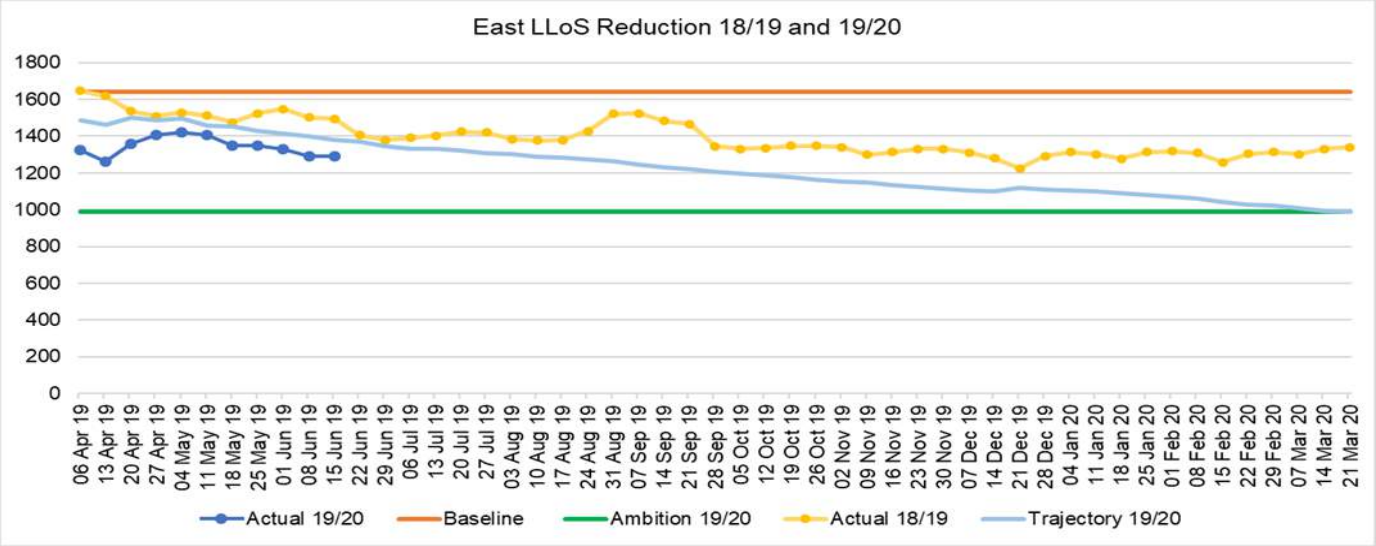
Appendix 2

GP streaming & Minors performance: Significant variation in volume of patients Streamed. A couple of the trusts (NNUH & West Herts) with the lowest Minors performance also have the lowest streaming volumes although some trusts with low streaming levels record high Minors performance.
Weekend discharges: All trust show a significant reduction in the average number of weekend compared to weekday discharges.

	GP Streaming (% A&E Attends Streamed)	A&E Minor 4 Hour Performance	Percent difference between weekend and weekday discharges	Beds occupied by long stay (21+ day) patients
	Daily Sitrep	Daily Sitrep	SUS	Daily Sitrep
Trust Name	Jun-19	Jun-19	Apr-19	WC 24th Jun-19
Basildon & Thurrock FT	0.0%	94.6%	-30.8%	70
Bedford Hospital	9.3%	99.9%	-36.2%	46
Cambridge UH FT	7.7%	100.0%	-27.6%	159
East & North Hertfordshire	11.5%	93.4%	-31.9%	52
East Suffolk & North Essex FT	3.1%	95.2%	-33.5%	140
James Paget FT	3.9%	93.0%	-40.3%	53
Luton & Dunstable FT	31.6%	100.0%	-34.9%	71
Mid Essex Hospital	5.4%	92.4%	-25.0%	66
Milton Keynes FT	2.0%	97.3%	-42.8%	91
Norfolk & Norwich FT	3.0%	83.0%	-31.7%	122
North West Anglia FT	0.1%	97.6%	-34.6%	129
Southend FT	20.2%	86.1%	-34.4%	62
The Princess Alexandra	7.6%	90.2%	-30.9%	37
The Queen Elizabeth King's Lynn FT	12.9%	96.2%	-41.3%	57
West Hertfordshire Hospitals	1.0%	88.2%	-30.3%	85
West Suffolk FT	6.6%	100.0%	-28.0%	53

Appendix 3

Overall EoE is on track to deliver the 40% ambition by March 20. However, two trusts (MK and NWAFT) are struggling to deliver their allocated target.



	Mar-18 baseline	W/C 08 Jun 19	W/C 15 Jun 19	W/C 22 Jun 19	Ambition		Achieved so far		To Go	
BASILDON	108	93	82	70	72	-33%	-38	-35%		
BEDFORD	78	57	58	50	39	-50%	-28	-36%	-11	-14%
CAMBRIDGE	225	179	168	155	92	-59%	-70	-31%	-63	-28%
EAST SUFFOLK	165	121	133	139	115	-30%	-26	-16%	-24	-15%
EAST AND NORTH HERTS	74	45	45	49	55	-26%	-25	-34%		
JAMES PAGET	65	39	47	52	45	-31%	-13	-20%	-7	-11%
LUTON AND DUNSTABLE	113	76	73	69	63	-44%	-44	-39%	-6	-5%
MID ESSEX	74	63	62	63	52	-30%	-11	-15%	-11	-14%
MILTON KEYNES	104	83	82	88	53	-49%	-16	-16%	-35	-33%
NORFOLK AND NORWICH	132	123	121	122	85	-36%	-10	-8%	-37	-28%
NORTH WEST ANGLIA	120	124	127	128	77	-36%	8	7%	-51	-43%
SOUTHEND	55	56	48	62	52	-5%	7	14%	-10	-19%
PRINCESS ALEXANDRA	68	35	41	43	39	-43%	-25	-36%	-4	-7%

QUEEN ELIZABETH	63	59	68	60	45	-29%	-3	-4%	-15	-24%
WEST HERTFORDSHIRE	130	83	83	84	65	-50%	-46	-36%	-19	-14%
WEST SUFFOLK	67	53	52	53	40	-40%	-14	-22%	-13	-19%
EAST TOTAL	1,621	1,289	1,289	1,287	989	-39%	-354	-21%	-298	-18%

Source: SitRep Data; NHSE/I Analytical team

Appendix 4

Overall DToC remain above the 3.5% target but there has been a significant reduction when compared to same period last year. However, NHS delays especially high for the most challenged systems.

Provider perspective (NHS Acute Trusts only)	Apr-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
ENGLAND	**4.0%**	**3.6%**	**3.3%**	**3.3%**	**3.5%**	**3.4%**	**3.1%**
East of England	**4.1%**	**4.1%**	**3.5%**	**3.5%**	**3.4%**	**3.3%**	**3.1%**
East And North Hertfordshire	1.6%	1.9%	1.4%	1.2%	1.4%	2.1%	1.4%
The Princess Alexandra Hospital	3.1%	1.9%	1.1%	1.2%	1.6%	1.6%	2.1%
West Hertfordshire Hospitals	4.6%	4.2%	3.9%	3.6%	3.7%	2.9%	3.5%
Bedford Hospital	2.1%	3.6%	2.8%	2.8%	2.5%	3.0%	5.1%
Luton And Dunstable University Hospital FT	2.6%	2.5%	1.9%	2.1%	1.9%	2.4%	2.9%
Milton Keynes University Hospital FT	6.3%	4.2%	3.9%	3.8%	5.0%	5.2%	4.2%
Cambridge University Hospitals FT	7.7%	6.6%	5.5%	6.6%	5.9%	5.2%	4.6%
North West Anglia FT	8.1%	8.9%	8.0%	8.5%	8.6%	7.7%	5.8%
Royal Papworth Hospital FT	0.0%	0.5%	0.5%	1.1%	0.5%	0.7%	0.3%
Basildon And Thurrock University Hospitals FT	1.2%	2.1%	2.5%	2.8%	2.9%	0.8%	1.0%
Mid Essex Hospital Services	2.0%	2.5%	2.4%	1.7%	2.5%	1.6%	1.7%
Southend University Hospital FT	2.3%	1.8%	1.6%	1.5%	1.5%	1.8%	2.1%
James Paget University Hospitals FT	2.5%	6.0%	1.6%	2.6%	1.9%	2.1%	1.8%
Norfolk And Norwich University Hospitals FT	4.5%	3.5%	3.9%	4.1%	2.2%	3.3%	3.1%
The Queen Elizabeth Hospital, King's Lynn, FT	5.0%	6.5%	5.6%	2.8%	3.2%	4.0%	2.2%
Colchester Hospital FT (merged 01/07/18)	3.8%						
Ipswich Hospital (merged 01/07/18)	6.2%						
East Suffolk & North Essex FT (from 01/07/18)	5.1%	4.1%	3.7%	3.2%	3.3%	3.2%	3.2%
West Suffolk FT	4.1%	3.6%	3.8%	3.3%	4.3%	4.7%	4.8%

Source: SDCS, Monthly DToC SITREP + KHO3 beds occupied (PUBLIC)

Acutes only

Above 3.5%

2.5% - 3.5%

Appendix 5

A significant number of systems are failing to deliver the requirement to have 50% of the care homes actively using the bed tracker. There is therefore a risk of existing capacity which could help speed up discharges being underutilised.

STP	CCG	Total No. of Care Homes	Active (declaring capacity)	50% Target	No CHs needed to reach 50%	Digital Tool
Mid and South Essex	NHS Basildon And Brentwood CCG	53	16	27	11	OLM
	NHS Castle Point And Rochford CCG	32	19	16	-3	NECS
	NHS Mid Essex CCG	97	25	49	24	OLM
	NHS Southend CCG	97	55	49	-7	NECS
	NHS Thurrock CCG	33	17	17	-1	NECS
Bedfordshire, Luton and Milton Keynes	NHS Luton CCG	41	29	21	-9	NECS
	NHS Bedfordshire CCG	133	88	67	-22	NECS
Cambridge and Peterborough	NHS Cambridgeshire And Peterborough CCG	175	42	88	46	Sundown solutions
Hertfordshire and West Essex	NHS East And North Hertfordshire CCG	117	20	59	39	OLM
	NHS Herts Valleys CCG	148	21	74	53	OLM
	NHS West Essex CCG	49	9	25	16	OLM
Norfolk	NHS Great Yarmouth And Waveney CCG	86	9	43	34	In House
	NHS North Norfolk CCG	106	10	53	43	In House
	NHS Norwich CCG	63	5	32	27	In House
	NHS South Norfolk CCG	87	21	44	23	In House
	NHS West Norfolk CCG	56	10	28	18	In House
Suffolk and North East Essex	NHS Ipswich And East Suffolk CCG	98	17	49	32	Beautiful Information
	NHS North East Essex CCG	186	21	93	72	OLM
	NHS West Suffolk CCG	51	15	26	11	Beautiful Information

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23 July 2019

Dear Ann

ED Performance and related matters

Thank you for your letter of 05 July touching upon areas including GP streaming, SDEC, system 7DS and reducing long length of stay. Please accept my apologies for not responding to you by 19 July. The original letter had not been specific on response expectations and we failed to note the deadline specified in your 10 July follow-up email. We had been gearing up to discussing these issues with colleagues from the regional team at our scheduled PRM on 25 July.

Whilst we are of course conscious of the need to improve performance in all of these areas, there are a couple of metrics where we are keen to be guided by your team in relation to precise definitions and methodology – in order that we can reproduce the figures and use them to actively drive and track improvement. Specifically, this relates to the definition of SDEC (where your letter acknowledges ongoing work nationally) and streaming. In the case of streaming, we are unclear whether the denominator is *patients attending a type 1 ED*, or all patients. In respect of some metrics, we are a little unclear as to whether the outcome sought is simply a local improvement trajectory or if there is an implied 'league table': for example, with respect to streaming the presence of a common front door (or otherwise) for an ED and an urgent care centre (UCC) will render comparison between organisations difficult. The team will discuss further at the forthcoming PRM.

With these caveats, please note out initial responses on the various topics raised below:

1. Streaming / ED Minors performance

Our current baseline is described as 2%. We note that defining what is achievable in our own context may be a challenge – particularly on a site with a local UCC but one which does not share a common front door.

In terms of actions:

- We are focusing on ensuring that 08:00 to 20:00 streaming hours (7 days per week) are being met. At times of nursing staff shortages, the streaming role has on occasion been suspended in order to bolster staff numbers in the main department. We plan to: (a) prioritise filling 100% of streaming shifts and (b) undertake a trial of UCC employees undertaking the streaming function to see if this can increase stream rates.

- We will set ambitious and SMART improvement trajectories for both streaming and ED minors performance (97.3% in June 2019) by 30 September (based on our experience of the measures above).

- As part of the usual breach analysis process, acuity flags (through which 'minors' patients are categorised) will now be reviewed and validated.

- In addition to our daily analysis of ED breach reasons, we will reinvigorate fortnightly breach review meetings led by our Assistant Director of Operations (Medicine), with review of themes, involvement from other Divisions and a focus on learning.

In relation to ongoing audit work:

- We have a routine feedback mechanism in place with the UCC on patients streamed inappropriately.

- A sample of 50 'minors' cases has been reviewed by UCC staff – could these patients have been streamed?

- Involvement of UCC staff in streaming (as described above) in order to provide peer review.

2. Same Day Emergency Care

Our current ambulatory emergency care unit (AECU) is available 5 days per week, either 08:00 to 22:00 or 08:00 to 20:00 (64 hours in total). The current frailty service provision is via MKUH's AAFT team (acute medical unit) and the Home 1st Therapy team (Emergency Department) provided by Central and North West London (CNWL) NHS Foundation Trust. The MKUH service runs 7 days per week but provides only 56 hours per week (against the expectation of 70 hours per week).

In terms of actions:

- We are attempting to clarify with NHSE/I the methodology and definitions for calculating SDEC performance. At present, we are unable to replicate the figure quoted.

- We will develop an options appraisal in order to develop 7-day AECU / clinic space offering (12h per day) by 31 August, with a view to implementation on a pilot basis before the end of September 2019.

- We will develop an options appraisal in order to develop a 7-day frailty offering (10h per day), focusing on Home 1st Therapy and the team's ability to take patients out of hospital 7 days per week, leading to trajectory and funded plan by 31 October. We are conscious of the December 2019 goal for implementation. This work will require the support of commissioners and other partners at the MK Integration Board.

3. Weekend discharges and wider system 7DS

We would be interested to discuss the validity of this measure as the number of admissions is quite variable by day of the week. Unless that number of admissions is evened out, one would expect – in a 7DS – for the same degree of variability to be evident with respect to discharges. Naturally, we support the goal of facilitating discharges at weekends but would be keen that to see that the metric used does not have unintended consequences. A daily 'admission to discharge ratio' may be more appropriate, and we will look to model this for local use.

The current position of the community in relation to the 7-day provision of pharmacy, community reablement and social work (above and beyond hospital element of Home 1st) is not clear to the Trust, and we shall explore this further with commissioning and local authority colleagues.

The community urgent care home response is provided by the CNWL high impact team. Clarification is required on the service offer, and whether the 2h target is met. We shall explore this further with commissioning colleagues.

The care home capacity tracker is not currently digital in Milton Keynes (maintained as a spreadsheet). We shall explore this further with commissioning colleagues.

We note the DTOC goal of <3.5%. For us, this is 17 patients. The figure currently stands at 27 patients. Out of area patients (Buckinghamshire) are currently a specific challenge.

In terms of actions:

- We shall work with colleagues across the system to deliver the coherent system write up (single plan) envisaged. We will aim to have this plan agreed, and signed off by MK Integration Board, by 31 October.

4. Reducing Long Length of Stay (40% reduction in super-stranded)

Our local goal is 53 patients. There has been some improvement, but we acknowledge that progress is not where it needs to be. We were submitting data to the DPTL by the 04 July deadline.

In terms of actions:

- Ongoing work with the Trust's Length of Stay Programme Board, chaired by the Medical Director.
- Undertake a community bed base review (under the auspices of the MK Integration Board).
- Executive involvement in the 'long-stay Thursday' process.
- An invitation has been offered to ECIST to assist and advise.

I hope that this response outlining the work that we are undertaking is helpful, and we look forward to discussing it at the PRM later this week.

With kind regards.

Yours sincerely

Professor Joe Harrison
Chief Executive Officer

Copy

Ms Patricia Davies, Accountable Officer, MK CCG

Urgent and Emergency Care Operations

East of England Acute Trust Categories & Reporting
Quarter 2 (01 July to 30 September 2019)

NHS England and NHS Improvement

Introduction

Since October 2018 all acute trusts and systems within the East of England have been undertaking daily information submissions to the UEC Operations room via the national SITREP system and OPEL reports. NHSE&I recognise that these submissions utilise valuable resources and can often result in duplication.

Following feedback, the Regional Performance and Improvement team is keen to introduce and trial a quarterly based categorisation and related reporting model for trusts and systems. The chosen metrics align to National/Regional priorities and have been selected as they are key to achieving patient flow and timely patient care across the health system. It is acknowledged that individual trusts and systems will have their individual challenges due to variables such as, staffing, estates, finances, geographies and demographics.

The categorisations embedded within the slide deck aim to achieve the following:

- Apply simple methodology to achieve a consistent set of *metrics for reporting.
- Ensure detail and level or reporting is based upon risk and categorisation.
- Quarterly review of trust categorisation allowing Trusts change categories based on improvement or deterioration.
- Provides an opportunity for challenged organisations to receive targeted support, such as:

1. ECIST, (front door, flow, mental health & social care)
2. GIRFT
3. NHSE&I productivity teams (model hospital)
4. Sharing of regional and national best practice
5. Promote system working and optimisation of resources

***Categorisation data has been extracted from the national SITREP (trusts own data)**

The slides within this pack aim to be self explanatory, defining the categorisation and associated reporting requirements. The UEC operations team is keen to receive constructive feedback with the aim of reviewing and implementing amendments ahead of quarter 3.

NHSE&I are currently in the process of scoping the 2019/2020 winter assurance process and will be in communication with systems and providers in the near future.

Reporting & Communication Expectations

Since the coming together of NHSE&I, the regional UEC operations team has increased its direct communication with trusts and systems. The UEC operations team will primarily communicate with systems (CCGs / STPs) in the first instance, however the team will be having more regular contact with acute trusts when required. The team will aim to ensure that effective communication and sharing of information is maintained amongst internal and external stakeholders. As we move towards winter 2019/2020 the UEC team would like to have the opportunity to join system calls, as appropriate, the purpose of which will be to support the most challenged systems and avoid duplication of information requests during times of pressure.

We have taken the opportunity to embed an updated operations key contacts section for the NHSE&I Performance & Improvement Directorate.

August Bank Holiday 2019

Trusts are required to complete SITREP submissions for Friday, Saturday and Sunday of the Bank Holiday weekend on the Bank Holiday Monday. OPEL forms with need to be submitted by Trusts as per the guidance detailed within this document.

OPEL reports

OPEL reports should be submitted to the East of England UEC operations team via the CCG's Monday to Friday.

Email: england.er-uecoperations@nhs.net

Regional SITREP data

It has been confirmed that trusts and CCG's can have access to regional SITREP data using the national dashboard. Initially we will support the following having regional access:

- CCG's - Two named staff (one must be a Director)
- Acute Trust's - Two named staff (one must be a Director)

Please can you email the UEC operations team with the names of the staff who you wish to have access by 31 August 2017

Please adopt the new reporting model from Monday 19 August 2019

Trust Categories for Quarter Two

Based on Quarter One Performance

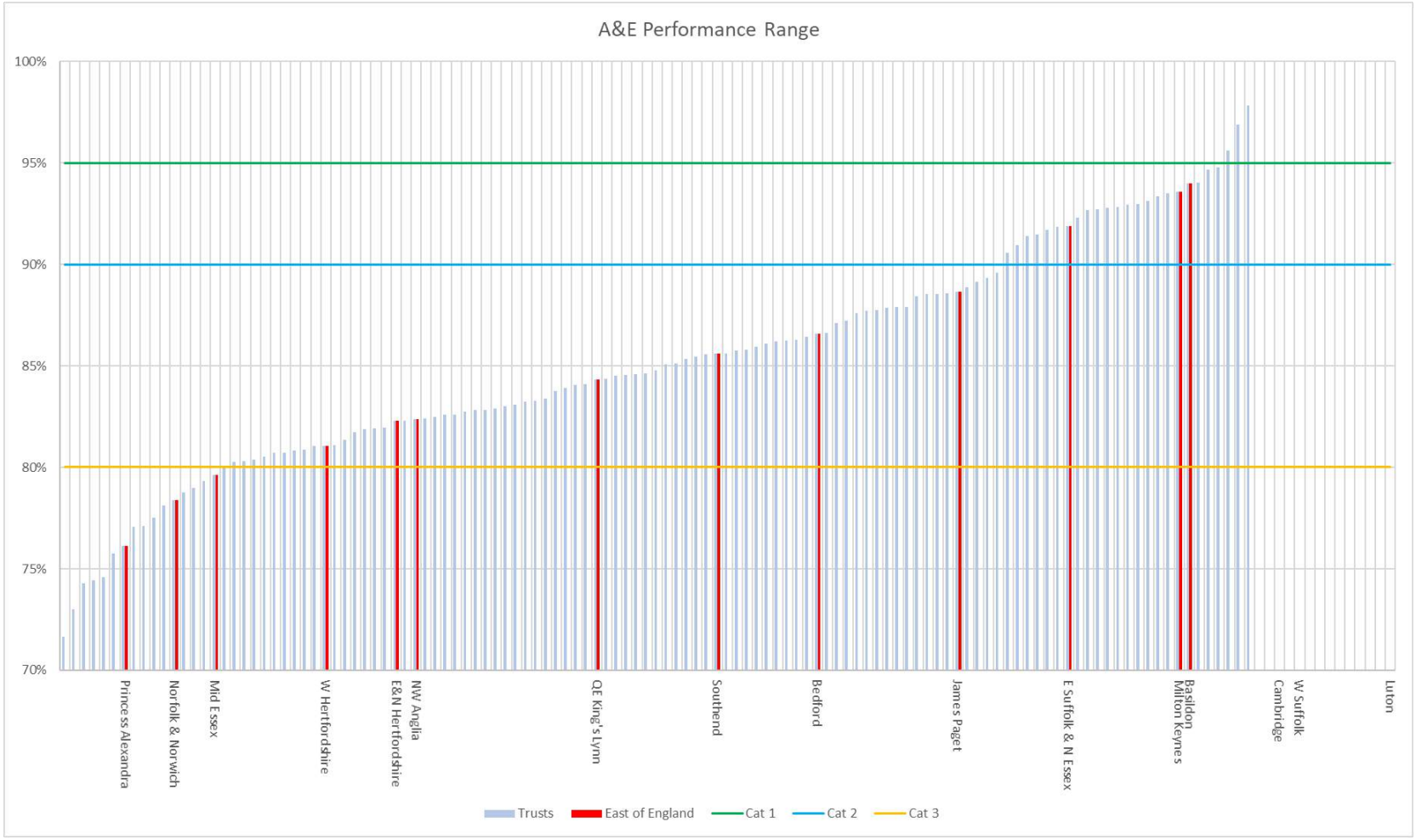
Category 4 = A&E performance C4 or 3+ C4 in supporting measures
Category 3 = 1 or 2 C4 in supporting measures or 3 or more C3
Category 2 = No more than 2 C3 in supporting measures
Category 1 = No C3 or C4

	Overall Rating	Key Measure A&E		Front Door						In A&E				Inpatient and Discharge					
				Streaming		Handover > 60		Handover > 30 to		A&E type 1		12 hour trolley		Bed occupancy		LLOS		DTOC	
		Actual	Group	Actual	Group	%	Group	%	Group	Actual	Group	Actual	Group	Actual	Group	Actual	Group	Actual	Group
East of England		85.2%		10.2%		**1.0%**		**5.1%**		**80.6%**		**23**		**94.1%**		**35.3%**		**3.8%**	
Cambridge	C4			11.0%	C2	0.5%	C1	4.6%	C1			1	C4	93.3%	C1	84.0%	C4	6.5%	C4
NW Anglia	C4	82.4%	C3	0.0%	C4	6.9%	C4	25.5%	C4	77.0%	C3	0	C1	92.4%	C1	62.2%	C4	6.1%	C4
E&N Hertfordshire	C3	82.3%	C3	17.0%	C1	3.4%	C3	11.7%	C3	74.3%	C3	0	C1	96.6%	C3	-5.3%	C1	3.3%	C2
Princess Alexandra	C4	76.1%	C4	8.9%	C2	1.1%	C2	13.9%	C3	73.5%	C3	7	C4	95.4%	C2	18.2%	C2	3.4%	C2
W Hertfordshire	C3	81.1%	C3	1.3%	C3	5.5%	C4	11.7%	C3	70.4%	C3	0	C1	90.4%	C1	40.7%	C4	5.0%	C3
Basildon	C3	94.0%	C2	0.0%	C4	0.2%	C1	3.5%	C1	94.0%	C1	0	C1	97.3%	C3	12.9%	C2	1.3%	C1
Mid Essex	C4	79.6%	C4	5.9%	C2	2.6%	C3	12.6%	C3	78.6%	C3	2	C4	95.4%	C2	18.2%	C2	1.9%	C1
Southend	C2	85.6%	C3	27.4%	C1	1.3%	C2	9.2%	C2	82.2%	C2	0	C1	92.4%	C1	17.7%	C2	4.7%	C3
Bedford	C3	86.6%	C3	14.1%	C1	1.0%	C1	3.1%	C1	80.8%	C2	0	C1	95.6%	C2	45.2%	C4	4.5%	C3
Luton	C2			45.9%	C1	1.1%	C2	11.2%	C3			0	C1	92.7%	C1	25.0%	C3	0.8%	C1
Milton Keynes	C3	93.6%	C2	3.1%	C3	0.4%	C1	5.1%	C2	89.8%	C2	0	C1	89.6%	C1	72.9%	C4	5.2%	C3
James Paget	C1	88.6%	C3	5.7%	C2	0.6%	C1	3.2%	C1	88.6%	C2	0	C1	95.6%	C2	19.1%	C2	3.1%	C2
Norfolk & Norwich	C4	78.4%	C4	12.6%	C2	1.7%	C2	12.9%	C3	64.5%	C4	16	C4	94.5%	C2	45.8%	C4	4.0%	C2
QE King's Lynn	C3	84.3%	C3	11.8%	C2	6.5%	C4	8.4%	C2	84.3%	C2	4	C4	93.4%	C1	20.1%	C3	2.4%	C1
E Suffolk & N Essex	C3	91.9%	C2	4.5%	C2	0.6%	C1	3.1%	C1	87.9%	C2	1	C4	95.6%	C2	15.1%	C2	3.1%	C2
W Suffolk	C3			7.1%	C2	1.7%	C2	9.1%	C2			0	C1	97.3%	C3	49.3%	C4	3.4%	C2

C1	95% and above	Over 15%	Below 1%	0% to 4.9%	90% and above	zero 12 hr waits	less than 94%	Achieve ambition	2.5% or below
C2	90% to 94.9%	4% to 14.9%	1% to 1.9%	5% to 9.9%	80% to 89.9%	N/A	94% to 95.9%	Within 20%	2.6% to 3.9%
C3	80% to 89.9%	0.1% to 3.9%	2% to 4.9%	10% to 14.9%	70% to79.9%	N/A	96% to 97.9%	Within 30%	4.0% to 5.9%
C4	Less than 80%	0%	Above 5%	Over 15%	Less than 70%	Any 12 hr waits	Over 98%	Over 30%	Over 6%

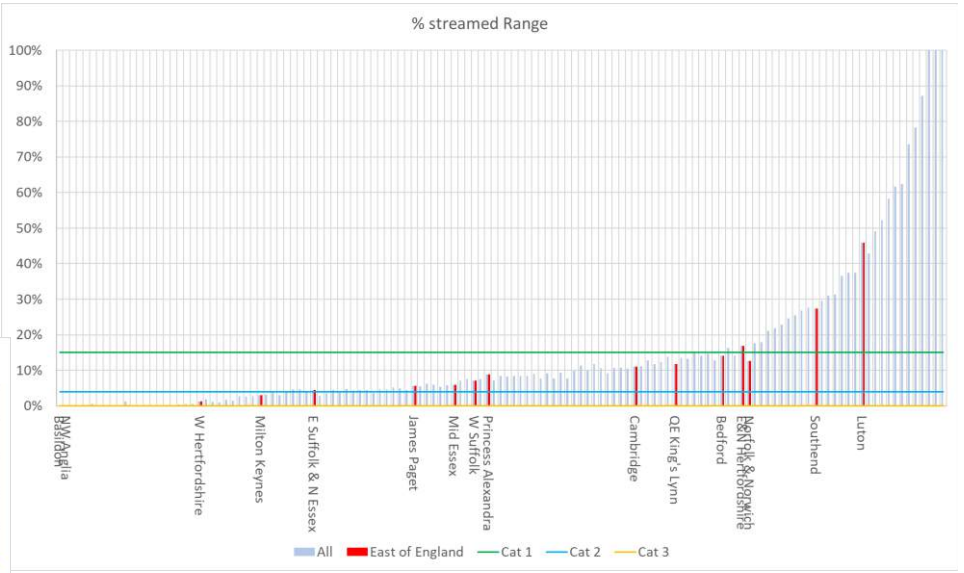
Please note that the Clinical Standard Review (CSR) sites overall categorisation rating has been considered. Within the Q1 data the categories remain unchanged due to the categorisation of metrics outside of the A&E performance metric.

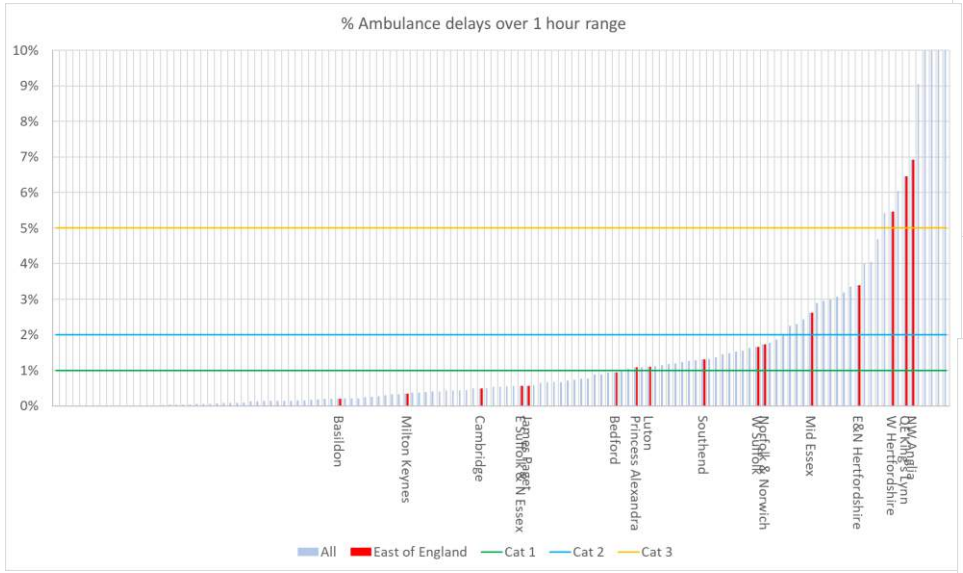
Profiles in more detail
Key Measure

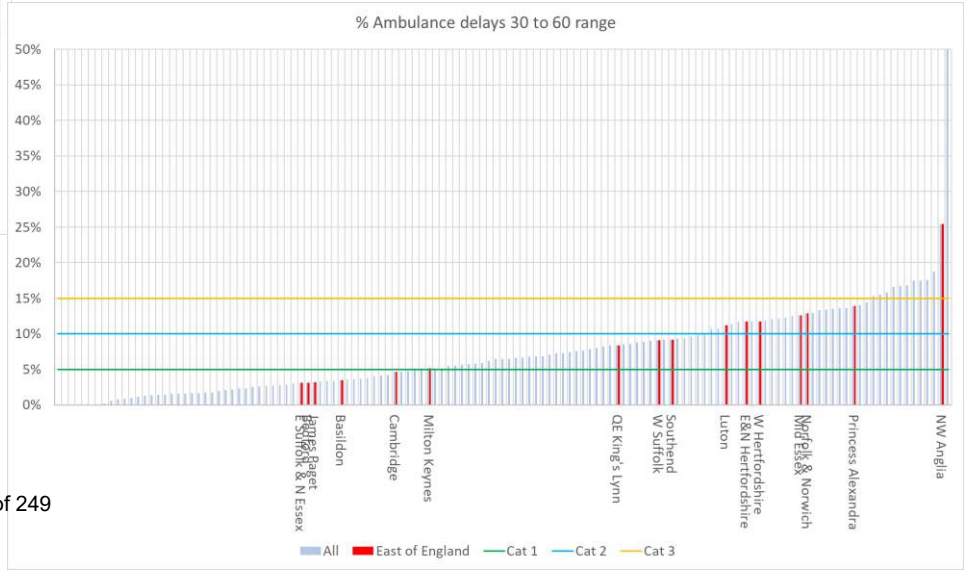


	A&E Performance
C1	95% and above
C2	90% to 94.9%
C3	80% to 89.9%
C4	Less than 80%

Profiles in more detail
Front Door







	Streaming	Handover > 60	Handover > 30 to 60
C1	Over 15%	Below 1%	0% to 4.9%
C2	4% to 14.9%	1% to 1.9%	5% to 9.9%
C3	0.1% to 3.9%	2% to 4.9%	10% to 14.9%
C4	0%	Above 5%	Over 15%

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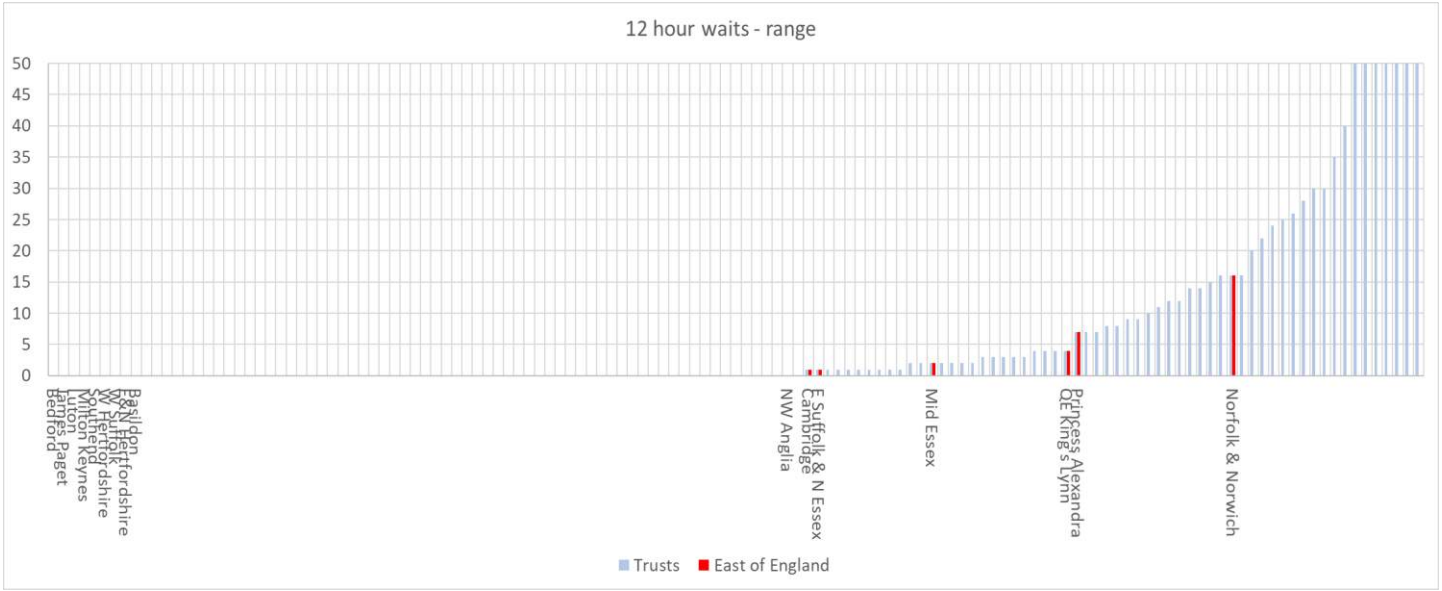
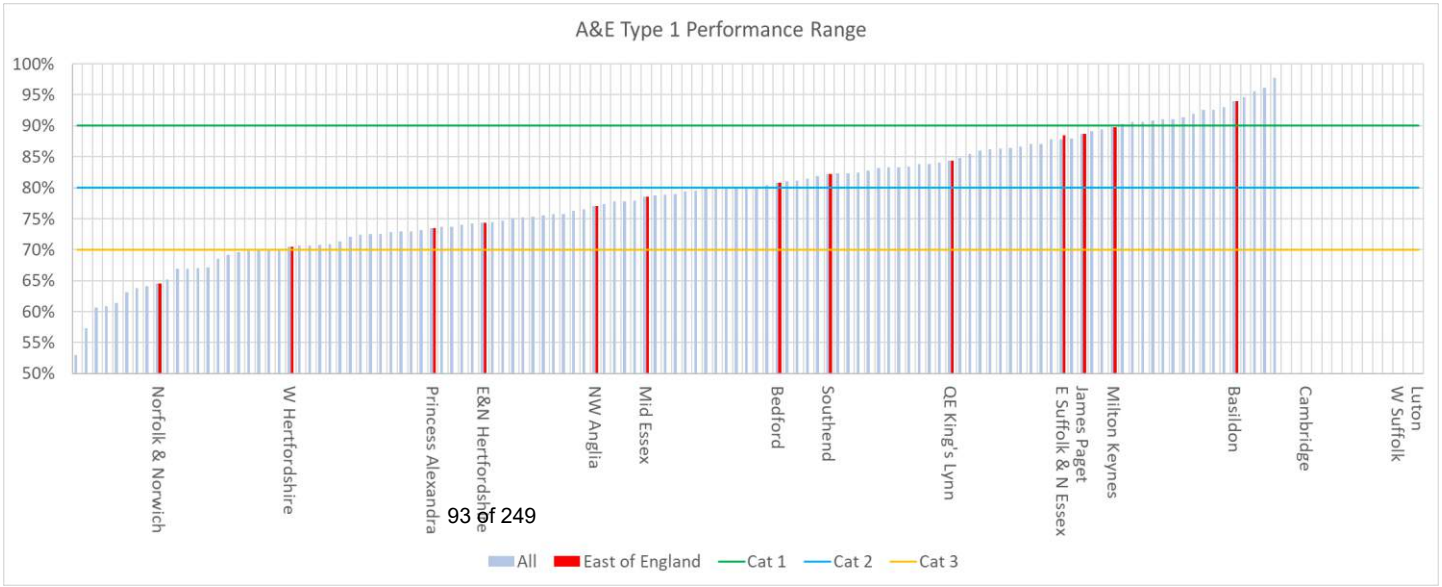
Profiles in more detail
In A&E

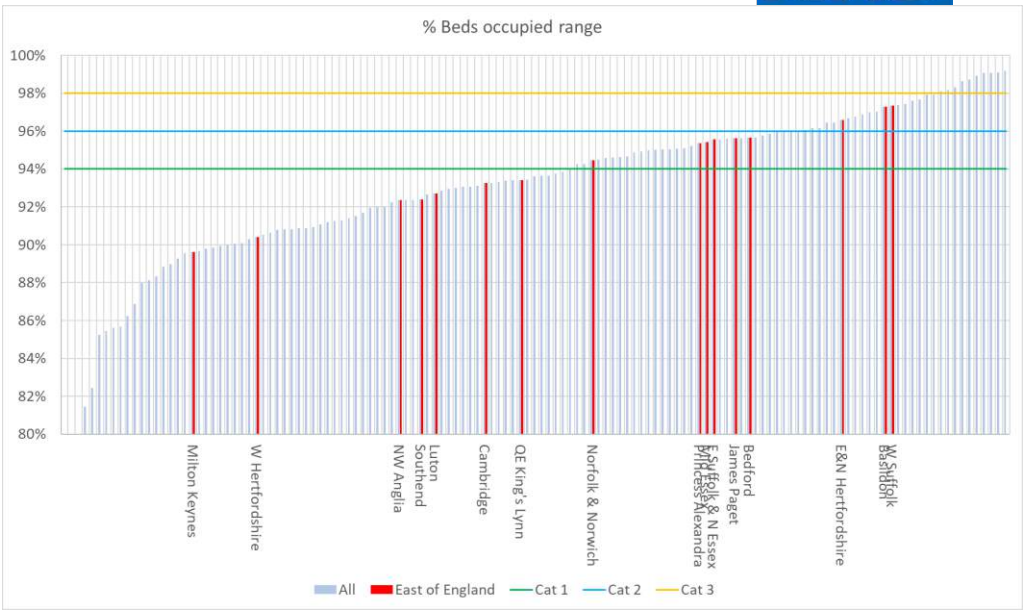
	A&E type 1 Performance	12 hour trolley waits
C1	90% and above	zero 12 hr waits
C2	80% to 89.9%	N/A
C3	70% to79.9%	N/A
C4	Less than 70%	Any 12 hr waits

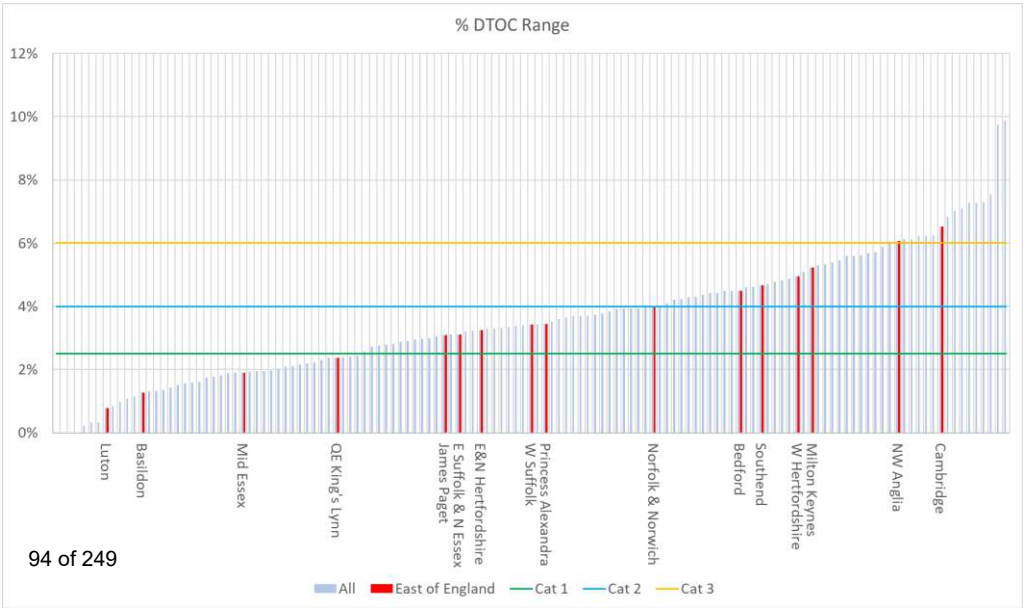




Profiles in more detail Inpatient and Discharge

	LLOS Ambition	Actual	Reduction required
East of England	989	1,338	35%
E&N Hertfordshire	55	52	
Basildon	72	81	13%
E Suffolk & N Essex	115	132	15%
Southend	52	61	18%
Princess Alexandra	39	46	18%
Mid Essex	52	61	18%
James Paget	45	54	19%
QE King's Lynn	45	54	20%
Luton	63	79	25%
W Hertfordshire	65	91	41%
Bedford	39	57	45%
Norfolk & Norwich	85	124	46%
W Suffolk	40	60	49%
NW Anglia	77	125	62%
Milton Keynes	53	92	73%
Cambridge	92	169	84%





	Bed occupancy	LLOS	DTOC
C1	less than 94%	Achieve ambitior	2.5% or below
C2	94% to 95.9%	Within 20%	2.6% to 3.9%
C3	96% to 97.9%	Within 30%	4.0% to 5.9%
C4	Over 98%	Over 30%	Over 6%

Metadata and notes

	Numerator	Denominator
A&E Performance	All type attendances within 4 hours	All type attendances
Streaming*	Patients streamed	Type 1 attendances
Handover > 60	Ambulance handover delays > 60	Total ambulance delays
Handover 30 to 60	Ambulance handover delays 30 to 60	Total ambulance delays
A&E type 1 Performance	Type 1 attendances within 4 hours	Type 1 attendances
12 hour trolley waits	Patients waiting 12 hours+ after decision to admit	
Bed occupancy	Total beds occupied	Total beds available
LLOS*	Patients in beds for 21 days or more minus Mar 20 ambition	Mar 20 ambition
DTOC	Patients whose transfer of care was delayed	Total beds occupied

*Nationally NHS E and I use all type attendances as the denominator to calculate % streamed. This is due to some type 3s being collocated with type 1s and some not bring collocated. The categorisation has used type 1 attendances as the denominator as locally some type 3 services are not collocated with the type 1.

*A small number of trusts are yet to agree the long stay reduction ambitions. The ambitions for those trusts who haven't agreed them will be updated when they are agreed

All data sourced from the daily sitrep

Regional Trust Categories (quarterly review)

Category 1	Category 2	Category 3	Category 4
• James Paget	• Southend • Luton & Dunstable *CSR site	• Queen Elizabeth Kings Lynn • East & North Hertfordshire • West Suffolk *CSR Site • Bedford • West Herts • Basildon & Thurrock • Milton Keynes • East Suffolk & North Essex	• NWAFT • Norfolk & Norwich • Princess Alexandra Hospital • Mid Essex • Cambridge *CSR site

Acute Trust Reporting

Category 1	Category 2	Category 3	Category 4
Acute trust reporting requirements by exception only to Regional UEC Operations (Use exception report) • 12 hour breach • > 10% drop in all type performance (previous 24 hours) • > 2 x 30/60 Ambulance Handover delays (previous 24 hours) • Corridor care in previous 24 hours • > 20 beds closed due to IPC issues • Escalation to OPEL 3 or OPEL 4 (need to submit OPEL report) • Disruption due to catastrophic events or loss of infrastructure where ED flow is disrupted	**Acute trust reporting requirements by exception only to Regional UEC Operations (Use exception report)** • 12 hour breach • > 10% drop in all type performance (previous 24 hours) • > 5 x 30 minute or 1 Ambulance Handover delays over one hour (previous 24 hours) • Any corridor care in previous 24 hours • > 20 beds closed due to IPC issues • Escalation to OPEL 3 or OPEL 4 (need to submit OPEL report) • Disruption due to catastrophic events or loss of infrastructure where ED flow is disrupted	**Acute trust reporting requirements to Regional UEC Operations** • Communication 5 days per week with NHSE&I relationship manager / UEC Operations room • Completion of OPEL reporting Monday, Wednesday & Thursday (including Bank Holiday Mondays) • Submission of 16:00 performance report to UEC Operations room Monday to Friday	**Acute trust reporting requirements to Regional UEC Operations** • Communication 7 days per week with NHSE&I relationship manager / UEC Operations room • Completion of OPEL reporting Monday to Friday (including Bank Holiday Mondays) • Submission of 16:00 performance report to UEC Operations room Monday to Friday

System Reporting Requirements

Category 1	Category 2	Category 3	Category 4
System reporting requirements by exception only to Regional UEC Operations • Shortage of community beds to facilitate effective discharge and flow • Staffing issues affecting system UEC functions and services • Disruption or significant under performance of UEC and supporting services • System at OPEL 3 or 4	**System reporting requirements by exception only to Regional UEC Operations** • Shortage of community beds to facilitate effective discharge and flow • Staffing issues affecting system UEC functions and services • Disruption or significant under performance of UEC and supporting services • System at OPEL 3 or 4	**System reporting requirements to Regional UEC Operations** • Communication Monday to Friday with UEC Operations room • Completion of OPEL reporting Monday, Wednesday & Thursday	**System reporting requirements to Regional UEC Operations** • Communication Monday to Friday with UEC Operations room • Completion of OPEL reporting Monday to Friday

NHSE&I Internal STP Leads

Bedfordshire, Luton and Milton Keynes ICS

Director: Nigel Coomber

NHSE ICS/CCG Lead: Georgie Brown and Shola

NHSI Trust Lead: Sara Howlett

UEC Ops: Paul Cleeland-Smith

Transformation Lead: Vicky Broom

Herts & West Essex STP

Director: Victoria Woodhatch

NHSE ICS/CCG Lead: Georgie Brown and Shola

NHSI Trust Lead: Deepa Nair

UEC Ops: Paul Cleeland-Smith

Transformation: Vicky Broom

Cambridge & Peterborough STP

Director: Alison Taylor

NHSE ICS/CCG Lead: Sara Howlett/Liz McEwan

NHSI Trust Lead: Sara Howlett

UEC Ops: Dave Ashford

Transformation Lead: Brin Hodgskiss

NHSE Trust Lead: Richard Woolsey

Mid & South Essex STP

Director: Victoria Woodhatch

NHSE STP/CCG Lead: Liz McEwan

NHSI Trust Lead: Aparna Belapurkar

UEC Ops: Dave Ashford

Transformation: Vicky Broom

NHSE Trust Lead: Debbie Wood

Norfolk & Waveney STP

Director: Alison Taylor

NHSE STP/CCG Lead: Liz McEwan

NHSI Trust Lead: Alison Hendron

UEC Ops: Dave Ashford

Transformation: Brin Hodgskiss

NHSE Trust Lead: Richard Woolsey

Suffolk & NE Essex STP

Director: Nigel Coomber

NHSE STP/CCG Lead: Ruth Forbes/ Liz McEwan

NHSI Trust Lead: Ruth Forbes

UEC Ops: Dave Ashford

Transformation: Brin Hodgskiss

NHSE Trust Lead: Debbie Wood

NHSE&I Workstream Framework - Performance & Improvement

The tables below aim to provide external stakeholders with an interim framework for the NHSE&I Performance & Improvement departmental workstreams and responsibilities.

UEC Operations Team - Day to day operational management, oversight and resolution of immediate challenges and patient safety issues.

Offer assurance and support:

- Daily Reporting including OPEL
- System escalation
- Escalation and communication with National UEC Operations
- Patient handover/ Ambulance
- Trust category 4 escalation (Regional Director & National UEC Director)
- Mental Health in Emergency Department
- UEC flow

Improvement & Delivery: Short-medium term challenges, improvement and delivery priorities and actions. OSM process and oversight.

- Emergency Department, R2G and Safer: Improved Flow
- Ambulance improvement
- Long Length of Stay
- GP Streaming
- RAPs / Trajectory / Delivery against plan / Improvement
- Annual Planning, Activity and in year monitoring of delivery for both CCGs and Trusts
- QIPP and CIPP development and delivery
- OSMs/ Audits
- ADBs
- Performance
  - 111
  - In / at Hospital
  - Out of hospital: CCG & Trust Community
- Mental Health in ED

Transformation: Delivery and coordination of 19/20 (and beyond) transformation ambitions and programmes.

- IUC
- UTCs
- Ambulance
- Hospital
- Hospital to Home / Ageing Well
- GP Five Year Forward View
- Digital

NHS
Milton Keynes University Hospital
NHS Foundation Trust

Meeting title	**Board of Directors**	**Date: 5 September 2019**
Report title:	**Mortality update report**	**Agenda item: 3.4**
Lead director **Report author** **Sponsor(s)**	**Dr Ian Reckless** **Dr Bina Parmar**	**Medical Director** **Associate Medical Director**
FoI status:	**Publically disclosable**	

Report summary				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Implementation and monitoring of the action plan			

Strategic objectives links	Improve patient safety
Board Assurance Framework links	Risk register ID reference 616
CQC outcome/ regulation links	Trust objective – patient safety **This report relates to CQC:** **Regulation 12 – Safe care & treatment** **Regulation 17 – Good governance**
Identified risks and risk management actions	Mortality data outside the expected range would be of public & regulatory body concern
Resource implications	None
Legal implications including equality and diversity assessment	This paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010

Report history	Regular update
Next steps	Implementation and monitoring of the action plan
Appendices	N/A

Executive Summary

This paper summarises the Trust's current position in relation to mortality based on the latest Dr Foster data available and as discussed through the Trust's mortality and morbidity (M&M) meeting framework.

The Trust's current HSMR and SHMI are both statistically 'as expected'. This figure has moved from below the national average, and over the last few months HSMR continues to climb. Co-morbidity recording has an impact on HSMR and since the introduction of e-care our Co-morbidity recording has been reduced. We are currently looking at a number of potential routes to improving comorbidity coding levels in eCare.

Medical Examiner Update – We will be looking to appoint another Medical Examiner to allow an approximate time of 45 minute review per case. This has been accepted regionally as the time required at the last Regional Mortality Review meeting. The team have seen a demonstration of Webex, a platform to host the mortality database. This platform can allow for Complaints, Claims and Mortality review to be viewed together allowing for better triangulation. Having access to this will be a possibility should the Trust decide to upgrade the current Datix Programme. There is now a feature on E-Care for Medical Examiners to allow entry to be made. The first meeting following implementation of the Medical examiners was held in July with the Registration Offices, Bereavement teams and Mortuary team. The KPI for registering a death within 5 days had fallen with the new process. Changes were implemented following the meeting and the registration office have reported back on the 27th August that this KPI is now being met.

We have requested our Mortality reports from Dr Foster to include a slide on LEDER deaths and will be requesting this for Mental health deaths too.

Definitions

Out of hours – Nights/weekends and bank holidays

Case mix – Type or mix of patients treated by a hospital

Morbidity – Refers to the disease state of an individual or incidence of ill health

Crude mortality – A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted

SMR - Standardised Mortality Rate (HSMR). A ratio of all observed deaths to expected deaths.

HSMR – Hospital Standardised Mortality Rate (HSMR). This measure only includes deaths within hospital for a restricted group of 56 diagnostic groups with high numbers of national admissions; it takes no account of the death of patients discharged to hospice care or to die at home. The HSMR algorithm involves adjustments being made to crude mortality rates in order to recognise different levels of comorbidity and ill-health for patients cared by similar hospitals.

SHMI – Summary Hospital-level Mortality Indicator (SHMI). SHMI indicates the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge.

Relative Risk – Measures the actual number of deaths against the expected number deaths. Both the SHMI and the HSMR use the ratio of actual deaths to an expected number of deaths as their statistic. HSMR multiplies the Relative Risk by 100.

- A HSMR above 100 = There are more deaths than expected
- A HSMR below 100 = There are less deaths than expected

Dr Foster

Third-party tools used to report the relative position of Milton Keynes University Hospital NHS Foundation Trust (MKUH) on national published mortality statistics. The trust recently renewed its relationship with Dr Foster Intelligence - therefore some of the graphs may look different.

HSMR

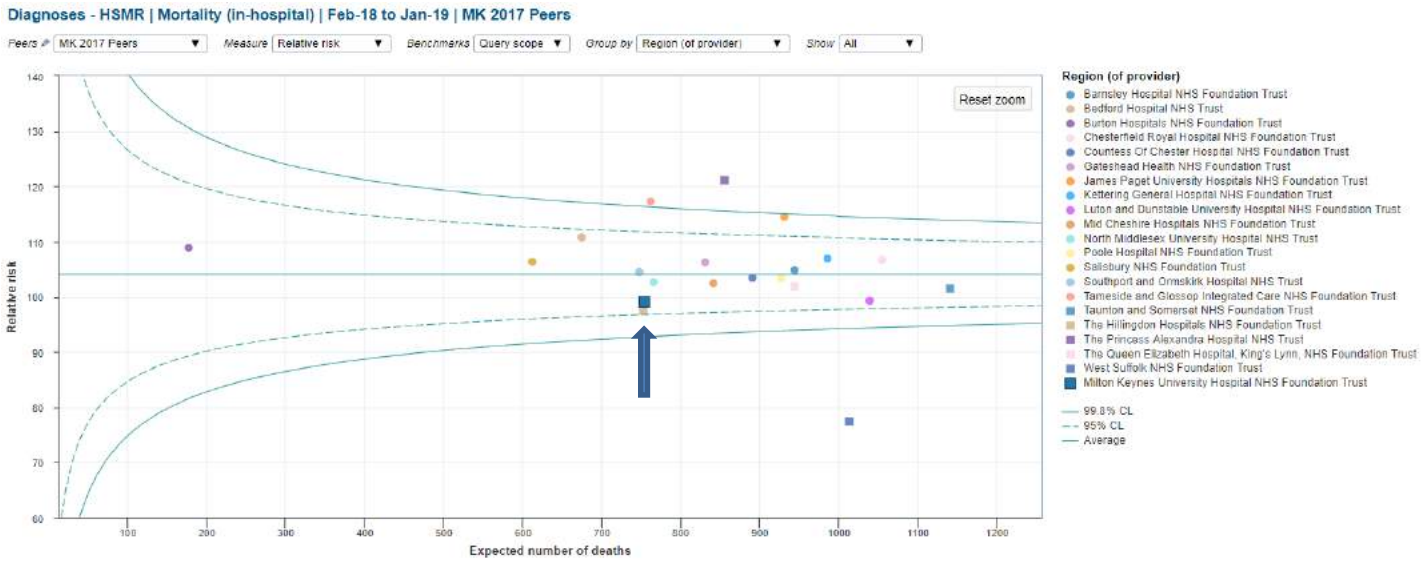
Data period: April 2018 to March 2019

Key Highlights:

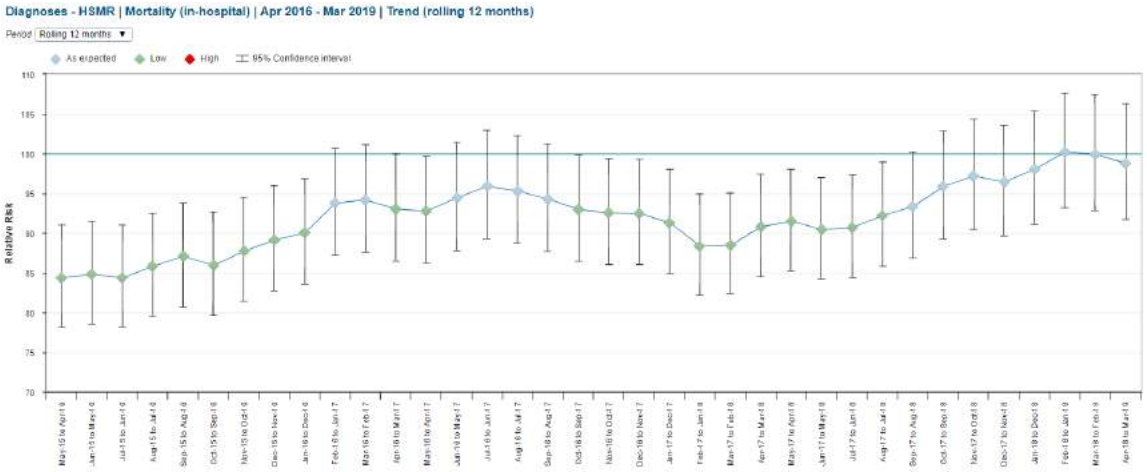
- HSMR relative risk for 12 month period = 98.7 'as expected' range
- The Trust has was in the 'as expected' banding in the last report to CQRC.
- The "as expected" banding is noted and a watching brief will be kept. It is unlikely that this change is significant in terms of care quality: it is noted that the palliative care coding rate has fallen a little, and also that the input data now includes months of coded data derived largely from electronic patient records which has had a negative impact upon coding depth and other aspects.
- Crude mortality rate within HSMR basket = **3.0%** (MKUH local acute peer group rate = 3.6%)
- 0 outliers were identified within the HSMR basket for this period.
- There are 2 observed deaths with a flag of intellectual Disability

The Trust's HSMR currently ranks 5th lowest (best) against its MKUH peer group (21 sites) and is very much in the middle of the group (see distribution below) when set against all national peers.

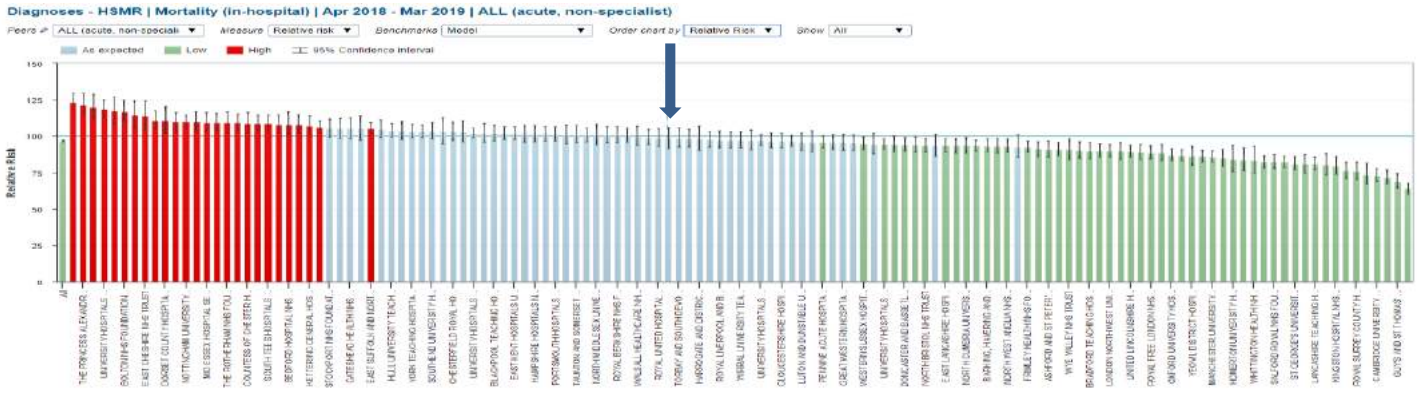
HSMR Funnel Plot – Trust vs. MKUH peer group (Apr 18 to Mar 19)

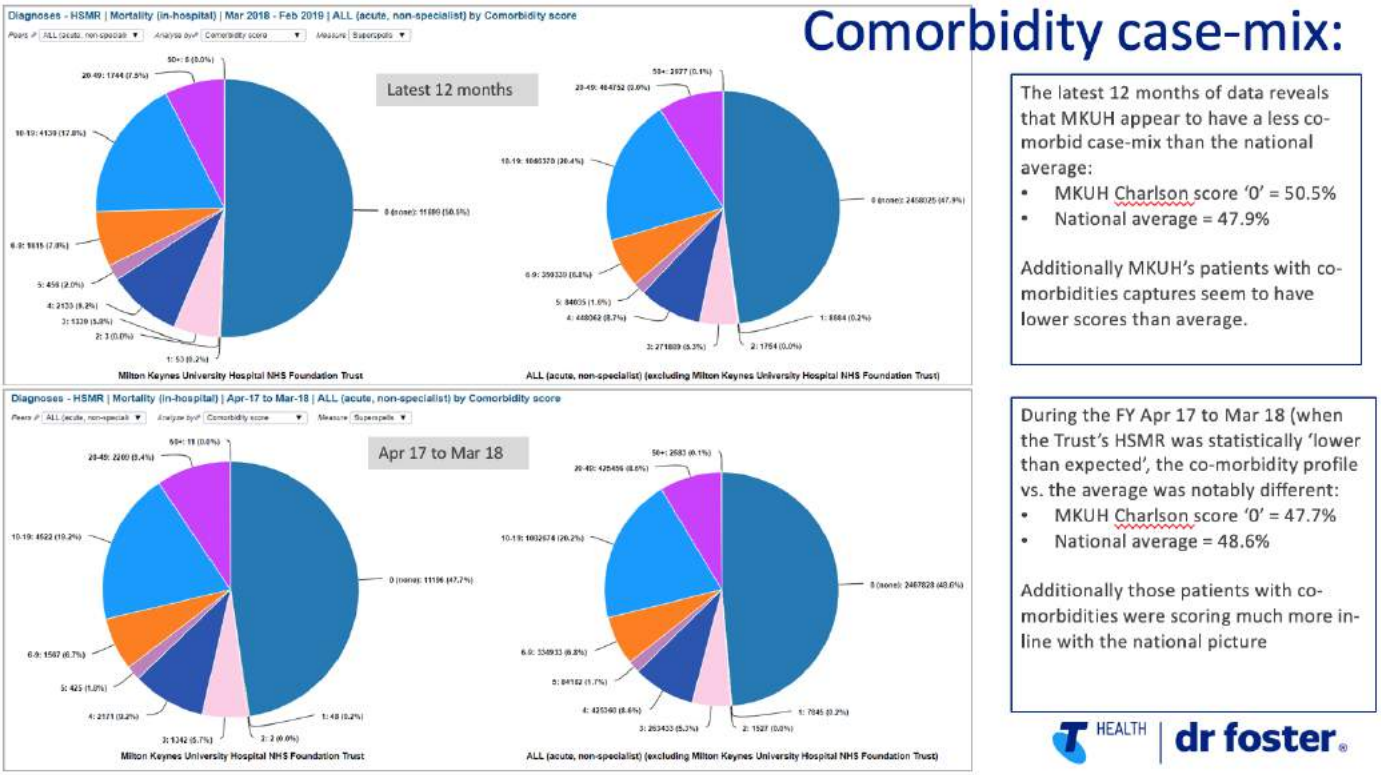


Trust level HSMR monthly performance trend (rolling 12 months) – last 36 months



HSMR position vs. national acute peers: Apr 18 – Mar 19





HSMR and Comorbidity

Over the last few months we have monitored our HSMR noticing a rising rate. Co-morbidity recording has an impact on HSMR and since the introduction of e-care our Co-morbidity recording has been reduced. We are currently looking at a number of potential routes to improving comorbidity coding levels in eCare. The Medical Examiners have a database which will be accessible to the coding team. A working group is in place, led by the Medical Director.

HSMR by diagnosis group:

An HSMR alert was previously in place for fractured of neck of femur. On the most recent data available, this alert is no longer present (odds ratio of death 138.9, confidence limits 89.9 to 205.1). However, for the purposes of assurance, some detail of the work done is shown below. Given the upward trend in reported HSMR noted above, it is likely that more alerts will emerge over time.

Figure 3 – HSMR by diagnosis group

There is 1 outlying diagnosis groups attracting significantly higher than expected deaths which it would be prudent to investigate:

- Fracture of neck of femur (hip) RR= 153.9 'higher than expected (29 deaths vs. 18.8 expected)
  Link to patient records: https://one.drfoster.com/Query/?id=1280097

Diagnoses - HSMR | Mortality (in-hospital) | Dec-17 to Nov-18 | Diagnosis group

Analyse by: Diagnosis group | Measure: Relative risk | Show: All

Diagnosis group	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	23,628	100.0%	23,867	755	3.2%	795.3	3.4%	-40.3	94.9	88.3	102.0
Fracture of neck of femur (hip)	269	1.1%	270	29	10.8%	18.8	7.0%	10.2	153.9	103.1	221.1
Urinary tract infections	952	4.0%	957	33	3.5%	24.7	2.6%	8.3	133.9	92.1	188.0
Acute cerebrovascular disease	298	1.3%	308	55	18.5%	50.9	17.1%	4.1	108.1	81.4	140.7
Aspiration pneumonitis, food/vomitus	136	0.6%	139	44	32.4%	39.6	29.1%	4.4	111.2	80.8	149.2
Other lower respiratory disease	291	1.2%	294	12	4.1%	7.7	2.6%	4.3	156.5	80.8	273.3

*NB: Top 5 groups shown (sorted by 'low' confidence interval – i.e bringing most 'outlying' groups to top of list)

Review of Cases

A review was undertaken when the alert came on. The conclusion of this review found that 22 out of 24 that have been reviewed in the Surgical M&M process judged the deaths as unavoidable. 2 are outstanding as they are under Medical M&M review. 23 (83%) of patients were aged over 80 at the time of death. 12 patients between the ages of 80-89 and 2 patients were over 100 years old. 1 patient died within 1 day of operation aged 106 years of age. The highest number of patients were admitted in February 2018 (6/28) whilst in November 2018 we saw the highest number of deaths (6/28). 26/28 patients had a DNACPR order in place at the time of death. All patients were identified to have significant comorbidities and frailty. 21 patients went to inquest and these were returned with an accident death verdict in 13/21, and a natural causes verdict in 7/21.

Divisional HSMR performance for rolling year (Apr 18 – Mar 19)

Divisional HSMR relative risk (RR) scores have been developed by attributing deaths in the Dr Foster basket of 56 diagnostic groups to the most appropriate division. A significant caveat must be provided when the data are dis-aggregated in this way. This is intended for information / screening purposes only, rather than purporting to provide any significant assurance in any direction.

Medical Division RR = 99.5 'as expected'. There were 0 neagtive outliers (by diagnosis group) (i.e. significantly higher than expected deaths).

Surgical Division RR = 92.5 'as expected'. There were 0 negative outliers.

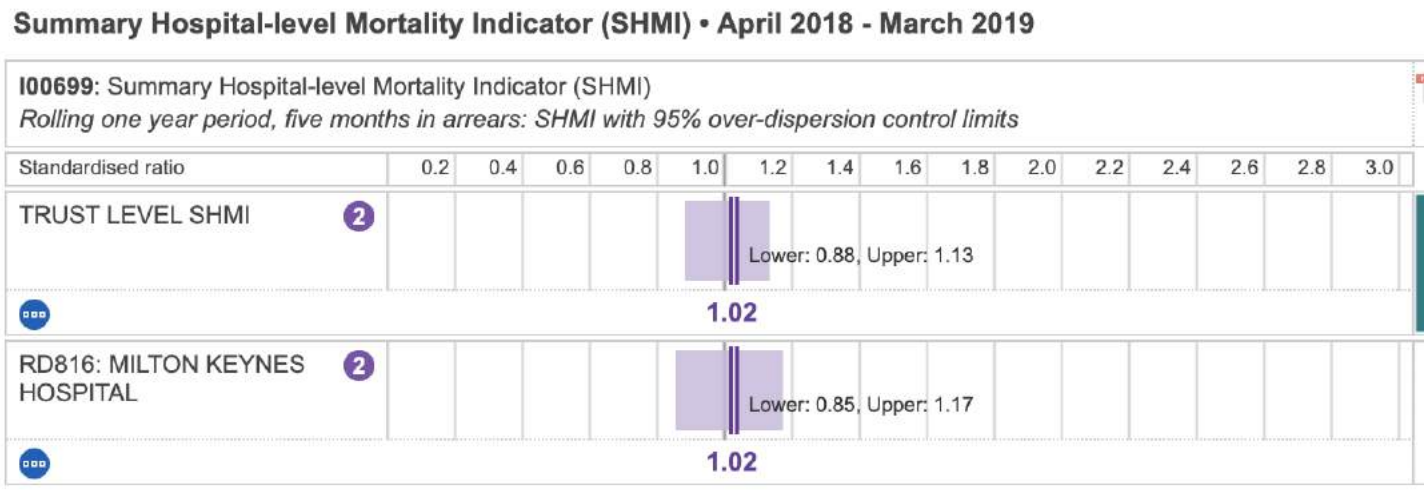
Women's and Children's Division RR = 77.2 'as expected'. There were 0 negative outliers.

SHMI

Data period: Apr 2018 – Mar 2019 (most up to date data available)

The Summary Hospital-level Mortality Indicator (SHMI), which includes out of hospital deaths occurring within 30 days of discharge, is measured by the Health and Social Care Information Centre (HSCIC). The SHMI relative risk is the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. A SHMI score below 1.00 is better than average.

Key Highlights:
The SHMI is 1.02 (with 10.5 months of eCare related clinical data incorporated).



Investigations of Deaths

The data for Q4, Q3, Q2 and provisional Q3 are illustrated in the graph below outlining the number of deaths within the Trust that have:

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

2. Undergone formal review – the Trust aims for ~ 25% of all deaths to undergo a formal review process however it is recognised that this figure may not been achieved for Q3 as winter pressures can lead to cancellation of some departmental M&M meetings. It should be recognised that deaths that occur within Q4 are still undergoing the process of formal review

as per the Trust Mortality policy and more complete data will be available for Q4 at the next Trust Board meeting.

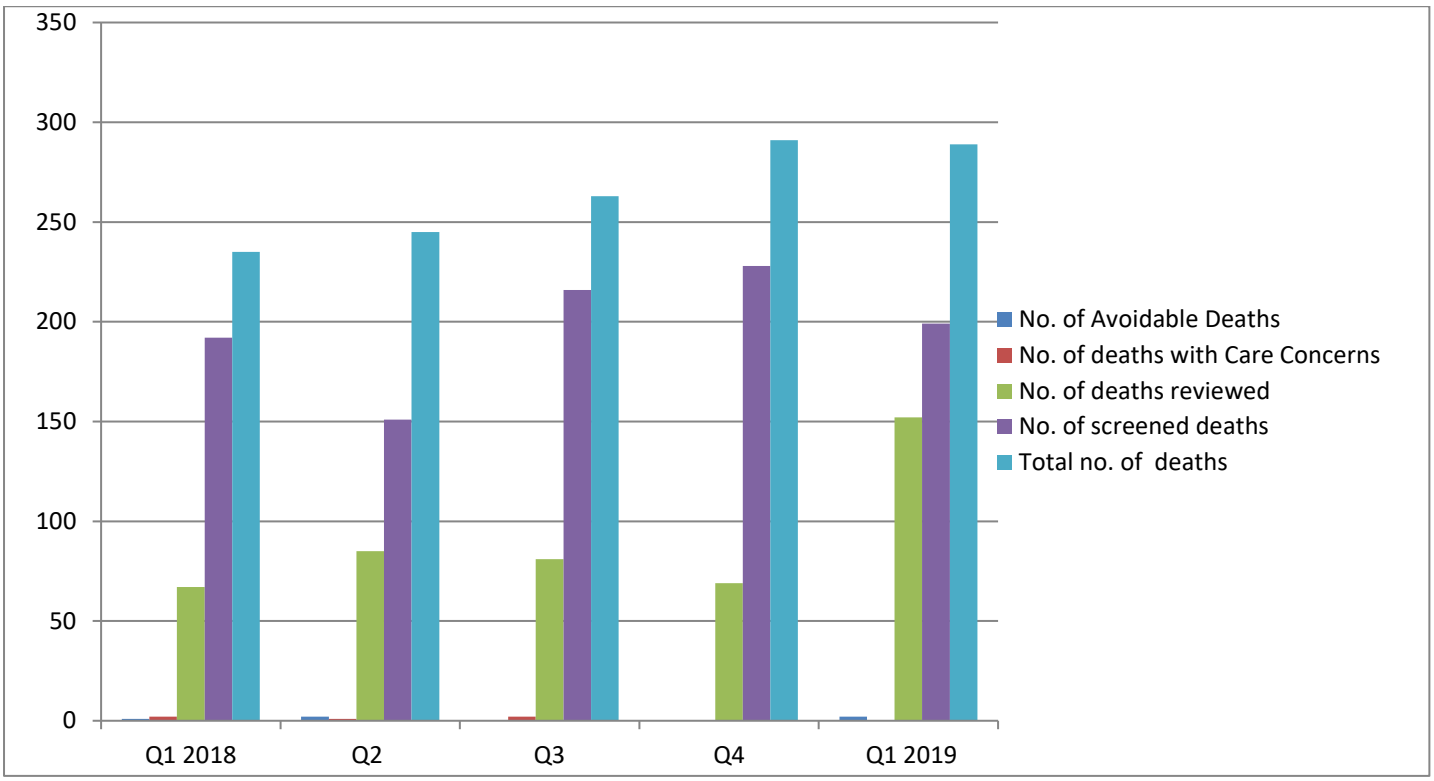
3. Judged as potentially 'avoidable' – using the current system of classification within the Trust this includes 'suboptimal care where different management MIGHT have changed outcome and 'suboptimal care where different management WOULD have changed outcome'

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

	Q1 2018/19	Q2	Q3	Q4	Q1 2019/20
No. of deaths	**235**	**245**	**263**	**291**	**289**
No. of deaths reviewed by responsible consultant (% of total)	**192 (81%)**	**151 (62%)**	**216 (82%)**	**228 (78%)**	**199 (68.8%)***
No. of investigations (% of total)†	**67 (29%)**	**85 (35%)**	**81 (31%)**	**69 (23.7%)**	**152(68.8%)***
No. of deaths with Care Quality concerns (%)	**2**	**1**	**2**	**1**	**0***
No. of potentially avoidable deaths (%)	**1**	**2**	**0**	**0**	**2***

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

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



Recent changes in the description and classification of deaths during the mortality review process have taken place. These minor changes mere made following discussions at Regional Network Mortality meetings led to agreement that all Trusts within the region would use the same classification method. The method (outlined below) below also includes the opportunity to recognoise excellent care.

Good or excellent care	No problems in care	Problems in care but very unlikely to have contributed to death	Problems in care but unlikely to have contributed to death	Problems in care more likely than not to have contributed to death

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 5 September 2019
Report title:	Performance Report indicators for 2019/20 (Month 4)	Agenda item: 4.1
Lead director Report author	Name: John Blakesley Name: Hitesh Patel	Title: Deputy Chief Executive Title: Associate Director of Performance and Information
FoI status:	Disclosable	

Report summary	Sets out the Trust's performance against key performance indicators at the end of July 2019			
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [x]	Decision [ ]
Recommendation				

Strategic objectives links	All Trust objectives
Board Assurance Framework links	None
CQC outcome/ regulation links	
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	None
Next steps	None
Appendices	None

Trust Performance Summary: M4 (July 2019)

1.0 Summary

This report summarises performance as at the end of July 2019 for key performance indicators and provides an update on actions to sustain or improve upon Trust and system-wide performance.

This commentary is intended only to highlight areas of performance that have changed or are in some way noteworthy.

2.0 Sustainability and Transformation Fund (STF)

Performance Improvement Trajectories

July 2019 performance against the Service Development and Improvement Plans (SDIP):

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		93.0%	89.9%	92.4%	90.5%	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		90.0%	90.9%		86.5%	✗	▼		
4.9	62 day standard (Quarterly)		85.0%	85.0%		82.8%	✗	▲		

In July 2019, 90.5% of patients were seen within 4 hours in ED. This was below the national standard of 95%. However, in the context of the Trust's NHS Improvement trajectory, it was ahead of the 89.9% commitment. The national A&E performance in July 2019 was 86.5%.

There was a 5.6% increase in the number of ED attendances during July 2019 (12,884) when compared to June 2019. This was the highest volume of attendances reported since the same month last year (July 2018), when the Trust experienced a similar drop in performance (88.9%).

The referral to treatment (RTT) 92% standard for incomplete pathways was not achieved at the end of July 2019. The aggregate performance was 86.5%, which was below the NHS Improvement trajectory of 90.9% for the month. This was however above the most recently published combined NHS England performance for RTT, which was 86.3% at the end of June 2019. Nationally, with the exception of February 2016, the operational standard for incomplete pathways has not been achieved since November 2015.

Cancer waiting times are reported on a quarterly basis, usually six weeks after the close of a calendar quarter. They are first released as provisional data, and subsequently finalised in line with the NHS England and NHS Improvement revisions policy. As per the provisional statistics for Q1 2019/20 (the most recent validated position), the Trust did not achieve the 85% Cancer 62 day standard, closing at 82.8%. This was also below the national performance which was 87.4% for the same period.

3.0 Urgent and Emergency Care

Performance in urgent and emergency care continued to function under increased pressure in July 2019, as reflected below.

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.8%	1.0%	✓	▼	✓	
3.2	Ward Discharges by Midday		30%	30%	24.8%	24.6%	✗	▲	✗	
3.4	30 day readmissions				8.2%	8.3%		▬		
3.9	Ambulance Handovers >30 mins (%)		5%	5%	6.0%	7.6%	✗	▼	✗	
4.1	ED 4 hour target (includes UCS)		93.0%	89.9%	92.4%	90.5%	✓	▼	✓	

Cancelled Operations on the Day

The number of elective operations cancelled on the day for non-clinical reasons in July 2019 was 29 (compared to 21 in June 2019). This represented 1% of all planned elective operations, which was within the agreed tolerance.

Of those cancelled on the day, insufficient time (9), bed unavailability (8) and scheduling errors (4) were described as reasons contributing to the majority of cancelled operations. Two each were also attributed to anaesthetist unavailability and medication issues. The remaining four were cancelled for other reasons, including equipment failure and further investigation needed.

Readmissions

The 30 day readmission rate remained consistent with the previous month at 8.3% in July 2019. At a divisional level, Medicine decreased from 13% in June 2019 to 12%, Surgery remained consistent at just over 5% but Women & Children reported its highest readmission rate since July 2018 at 5.6%.

Delayed Transfers of Care (DTOC)

The number of DTOC patients reported by the Trust at midnight on the last Thursday of July 2019 was reduced to 18. This was the fewest Delayed Transfers of Care reported since January 2019.

Length of Stay (Stranded and Super Stranded Patients)

The volume of super stranded patients with a length of stay of 21 days or more at the end of July 2019 increased by one to 94. This was above the NHS Improvement trajectory of 70 (trajectory to achieve the ambition of 53 by the end of March 2020). Reducing the number of stranded and super stranded patients releases capacity, improves patient experience and reduces the risk of infection.

Ambulance Handovers

In July 2019, the proportion of ambulance handovers to the Emergency Department that took longer than 30 minutes increased to 7.6%. This was the highest percentage reported since March 2019 and is perhaps reflective of the notable increase in demand on the department during the month.

4.0 Elective Pathways

ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	93.2%	93.9%	x	▼	x	
3.5	Follow Up Ratio		1.50	1.50	1.61	1.57	x	▲	x	
4.2	RTT Incomplete Pathways <18 weeks		90.0%	90.9%		86.5%	x	▼		
5.6	Outpatient DNA Rate		5%	5%	7.6%	7.5%	x	▼	x	

Overnight Bed Occupancy

Bed occupancy in July 2019 was the highest reported in the financial year to date and, at 93.9%, it was above the internal threshold of 93%. The latest overnight bed occupancy data published by NHS England reported that the average occupancy rate for general and acute beds nationally was 89.1% in Q4 2018/19, highlighting how demand for beds continues to offer a challenge for the Trust.

Follow up Ratio

Although the outpatient follow up ratio in July 2019 remained above the 1.5 threshold, it did exhibit a reduction to 1.57 follow up attendances for each new attendance. This was the lowest it has been in the financial year to date. Reducing follow up activity can free up capacity for new referrals.

RTT Incomplete Pathways

Meeting the 92% RTT standard and the NHS Improvement trajectory continues to be a challenge for the trust, with demand for emergency care undoubtedly having an impact on elective pathways.

Milton Keynes University Hospital has been selected by NHS Improvement/England as one of the field test sites to participate in the Elective Clinical Standards Review (CRS) Programme. This is likely to impact upon how the Trust reports elective waiting times, with the introduction of an average (mean) waiting time target for incomplete elective pathways being proposed by NHS England.

Diagnostic Waits <6 weeks

The Trust continued to meet the standard of less than 1% of patients waiting six weeks or longer for a diagnostic test in July 2019, with a performance of 99.4%. Nationally, the operational standard of less than 1% of patients waiting six weeks or more was not met in June 2019 (most recent report).

Outpatient DNA Rate

The DNA rate continued above the 5% threshold in July 2019. After a reported reduction during the previous month, it increased up to 7.5%. The 5% target has not been realised since April 2017.

DNAs represent clinic capacity that cannot be otherwise utilised. All services should ensure that they adhere to the Trust Access Policy and do everything they can to minimise DNA rates.

5.0 Patient Safety

Infection Control

MKUH reported zero cases of e-Coli, MRSA and MSSA infections in July 2019. However, two cases of CDI were reported this month, one was in Medicine (Ward 2) and the other in Surgery (Ward 21).

ENDS

Performance Report 2019/20
July 2019 (M04)

Milton Keynes University Hospital NHS Foundation Trust

OBJECTIVE 1 - PATIENT SAFETY										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
1.1	Mortality - (HSMR)		100	100		98.7	✓	▲		
1.2	Mortality - (SHMI) - Quarterly		1	1	1.01	1.01	✗	▲	✗	
1.3	Never Events		0	0	0	0	✓	▬	✓	
1.4	Clostridium Difficile		22	<8	3	2	✗	▼	✓	
1.5	MRSA bacteraemia (avoidable)		0	0	0	0	✓	▬	✓	
1.6	Falls with harm (per 1,000 bed days)		0.12	0.12	0.11	0.14	✗	▲	✓	
1.7	Midwife : Birth Ratio		28	28	29	28	✓	▼	✗	
1.8	Incident Rate (per 1,000 bed days)		40	40	51.38	52.32	✓	▲	✓	
1.9	Duty of Candour Breaches (Quarterly)		0	0	0	0	✓	▬	✓	
1.10	E-Coli		20	<7	5	1	✓	▼		
1.11	MSSA				0	0		▬		
1.12	VTE Assessment		95%	95%	98.0%	98.1%	✓	▲	✓	

OBJECTIVE 2 - PATIENT EXPERIENCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
2.1	FFT Recommend Rate (Patients)		94%	94%	*Not Available*					
2.2	RED Complaints Received				2	0		▬		
2.3	Complaints response in agreed time		90%	90%	88.6%	81.7%	✗	▼	✗	
2.4	Cancelled Ops - On Day		1.0%	1.0%	0.8%	1.0%	✓	▼	✓	
2.5	Over 75s Ward Moves at Night		2,111	704	718	195	✗	▼	✗	
2.6	Mixed Sex Breaches		0	0	0	0	✓	▬	✓	

OBJECTIVE 3 - CLINICAL EFFECTIVENESS										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
3.1	Overnight bed occupancy rate		93%	93%	93.2%	93.9%	✗	▼	✗	
3.2	Ward Discharges by Midday		30%	30%	24.8%	24.6%	✗	▲	✗	
3.3	Weekend Discharges		70%	70%	65.7%	57.8%	✗	▼	✗	
3.4	30 day readmissions				8.2%	8.3%		▬		
3.5	Follow Up Ratio		1.50	1.50	1.61	1.57	✗	▲	✗	
3.6.1	Number of Stranded Patients (LOS>=7 Days)		218	218		219	✗	▲		
3.6.2	Number of Super Stranded Patients (LOS>=21 Days)		53	70		94	✗	▼		
3.7	Delayed Transfers of Care		25	25		18	✓	▲		
3.8	Discharges from PDU (%)		15%	15%	8.2%	9.9%	✗	▲	✗	
3.9	Ambulance Handovers >30 mins (%)		5%	5%	6.0%	7.6%	✗	▼	✗	

OBJECTIVE 4 - KEY TARGETS										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
4.1	ED 4 hour target (includes UCS)		93.0%	89.9%	92.4%	90.5%	✓	▼	✓	
4.2	RTT Incomplete Pathways <18 weeks		90.0%	90.9%		86.5%	✗	▼		
4.3	RTT Patients Waiting Over 18 Weeks		1,399	1,262		1,874	✗	▼		
4.4	RTT Total Open Pathways		13,991	13,876		13,835	✓	▲		
4.5	RTT Patients waiting over 52 weeks			0		0	✓	▲		
4.6	Diagnostic Waits <6 weeks		99%	99%		99.4%	✓	▲		
4.7	All 2 week wait all cancers (Quarterly) ✎		93.0%	93.0%		94.1%	✓	▼		
4.8	31 days Diagnosis to Treatment (Quarterly) ✎		96.0%	96.0%		97.7%	✓	▼		
4.9	62 day standard (Quarterly) ✎		85.0%	85.0%		82.8%	✗	▲		

OBJECTIVE 5 - SUSTAINABILITY										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
5.1	GP Referrals Received		64,193	21,407	22,076	5,837	✗	▼	✗	
5.2	A&E Attendances		89,369	29,790	30,850	8,080	✗	▼	✗	
5.3	Elective Spells (PBR)		25,641	8,547	8,859	2,709	✗	▼	✗	
5.4	Non-Elective Spells (PBR)		31,976	10,711	10,422	3,011	✗	▼	✓	
5.5	OP Attendances / Procs (Total)		381,108	127,036	130,894	33,949	✓	▼	✗	
5.6	Outpatient DNA Rate		5%	5%	7.6%	7.5%	✗	▼	✗	

OBJECTIVE 7 - FINANCIAL PERFORMANCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
7.1	Income £'000		268,966	89,218	87,223	23,876	✗	▲	✗	
7.2	Pay £'000		(171,021)	(57,852)	(58,482)	(14,591)	✗	▼	✗	
7.3	Non-pay £'000		(77,803)	(26,386)	(26,253)	(6,771)	✗	▼	✓	
7.4	Non-operating costs £'000		(13,359)	(4,373)	(4,348)	(1,092)	✓	▼	✓	
7.5	I&E Total £'000		6,783	607	(1,859)	1,422	✗	▲	✗	
7.6	Cash Balance £'000		2,500	2,721		15,470	✓	▲		
7.7	Savings Delivered £'000		8,419	1,404	1,059	448	✗	▲	✗	
7.8	Capital Expenditure £'000		27,926	7,994	9,292	25	✓	▲	✗	

OBJECTIVE 8 - WORKFORCE PERFORMANCE										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
8.1	Staff Vacancies % of establishment		11%	11%		13.7%	✗	▼		
8.2	Agency Expenditure %		8%	8%	5.6%	5.2%	✓	▲	✓	
8.3	Staff sickness - % of days lost		4%	4%		4.0%	✓	▲		
8.4	Appraisals		90%	90%		90.0%	✓	▼		
8.5	Statutory Mandatory training		90%	90%		92.0%	✓	▼		
8.6	Substantive Staff Turnover		11%	11%		9.6%	✓	▲		

OBJECTIVES - OTHER										
ID	Indicator	DQ Assurance	Target 19-20	Month/YTD Target	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position	Rolling 15 months data
O.1	Total Number of NICE Breaches		8	8	*Not Available*					
O.2	Rebooked cancelled OPs - 28 day rule		95%	95%	83.2%	62.5%	✗	▼	✗	
O.4	Overdue Datix Incidents >1 month		0	0		110	✗	▼		
O.5	Serious Incidents		45	<15	18	5	✗	▬	✗	
O.8	Completed Job Plans (Consultants)		90%	90%		93%	✓	▬		

Key: Monthly/Quarterly Change

▲	Improvement in monthly / quarterly performance
▬	Monthly performance remains constant
▼	Deterioration in monthly / quarterly performance
	NHS Improvement target (as represented in the ID columns)
✎	Reported one month/quarter in arrears

YTD Position

✓	Achieving YTD Target
	Within Agreed Tolerance*
✗	Not achieving YTD Target
	Annual Target breached

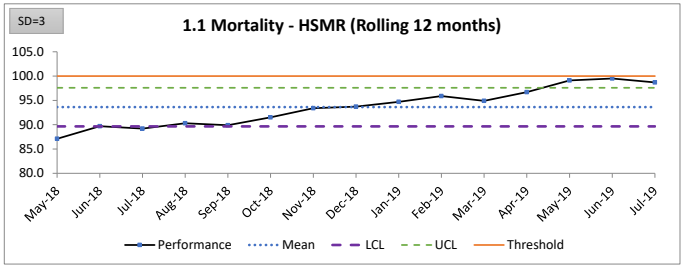
Data Quality Assurance Definitions

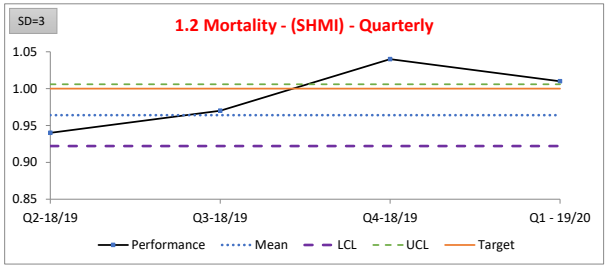
Rating	Data Quality Assurance
Green	Satisfactory and independently audited (indicator represents an accurate reflection of performance)
Amber	Acceptable levels of assurance but minor areas for improvement identified and potentially independently audited * /No Independent Assurance
Red	Unsatisfactory and potentially significant areas of improvement with/without independent audit

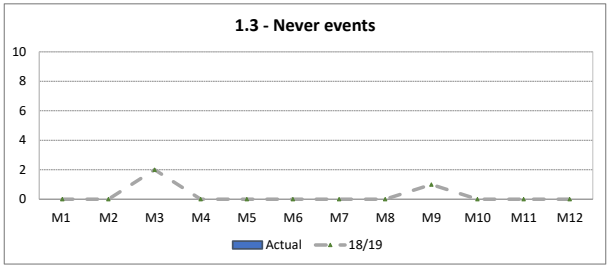
* Independently Audited – refers to an independent audit undertaken by either the Internal Auditor, External Auditors or the Data Quality Audit team.

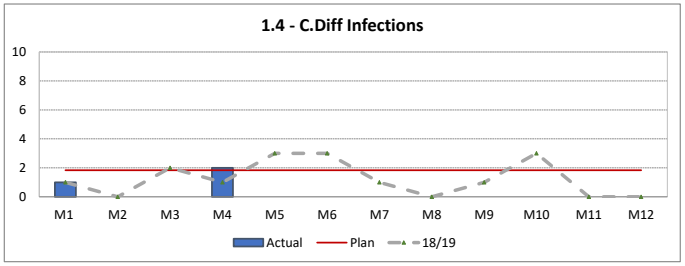
Date Produced: 13/08/2019

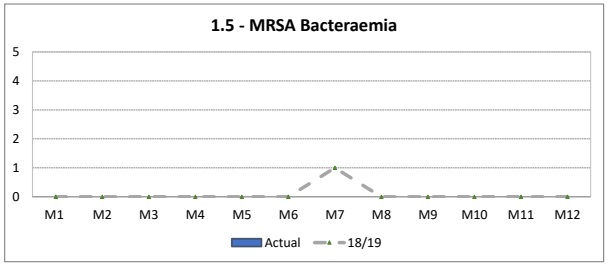
Milton Keynes University Hospital NHS Foundation Trust

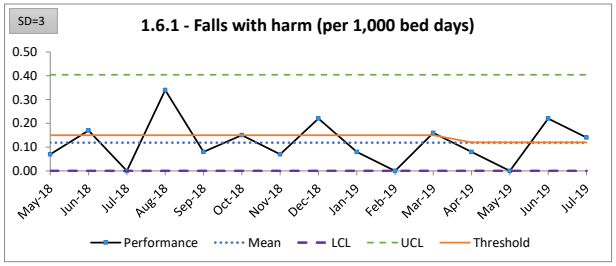


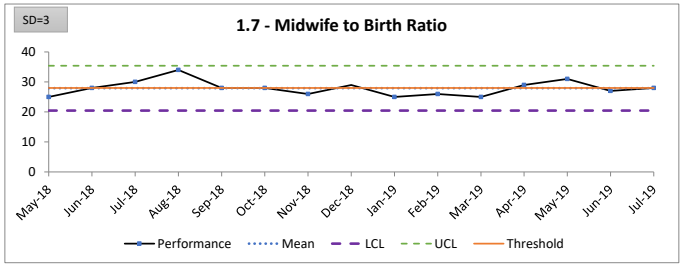


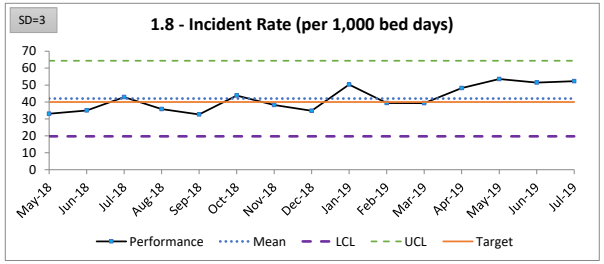


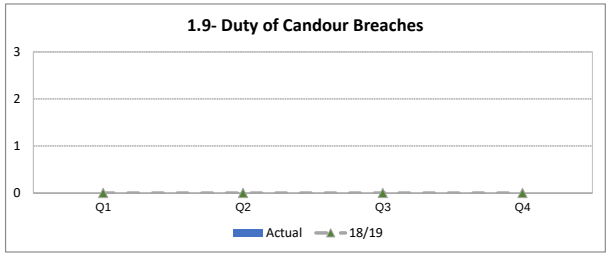


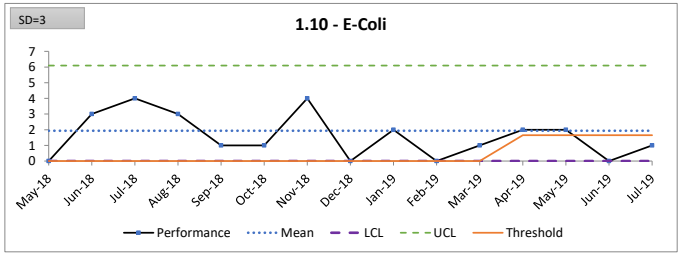


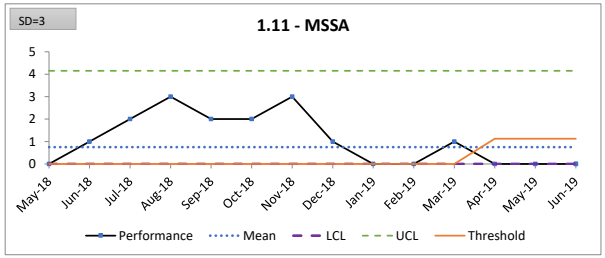


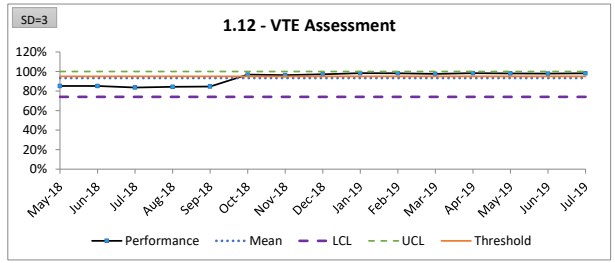












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- Average on a rolling 12 months/quarterly
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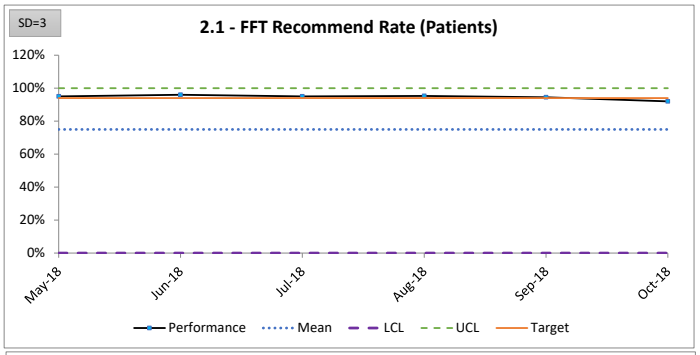
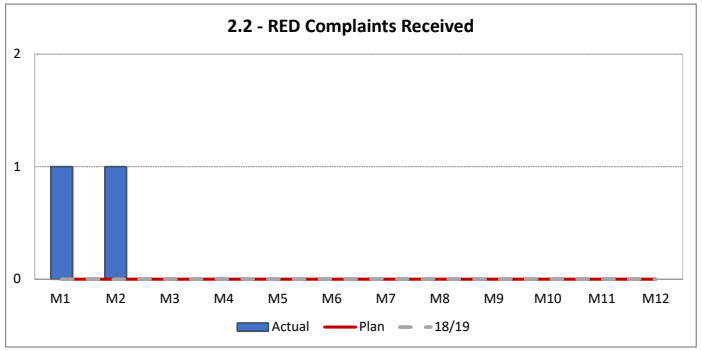
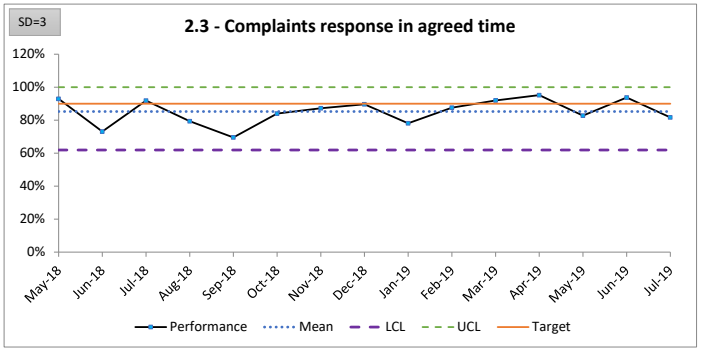
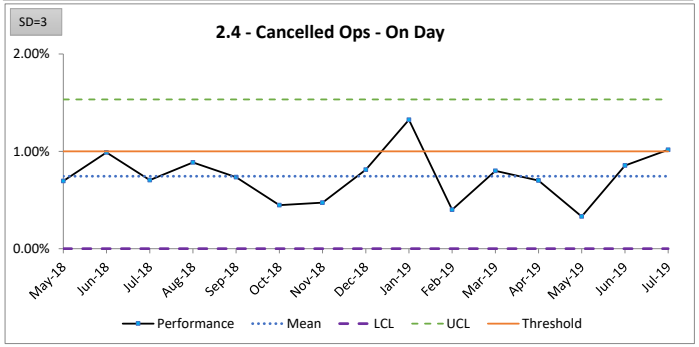
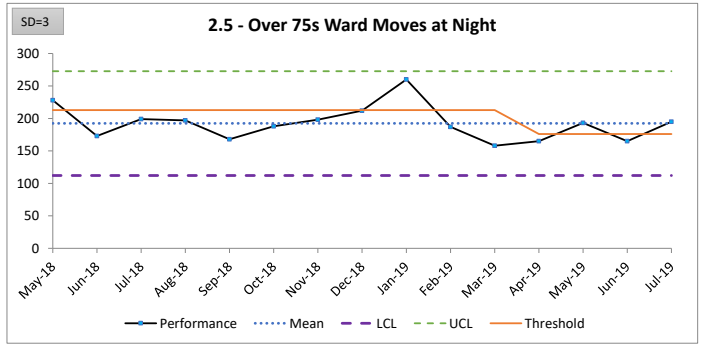
OBJECTIVE 2 - PATIENT EXPERIENCE

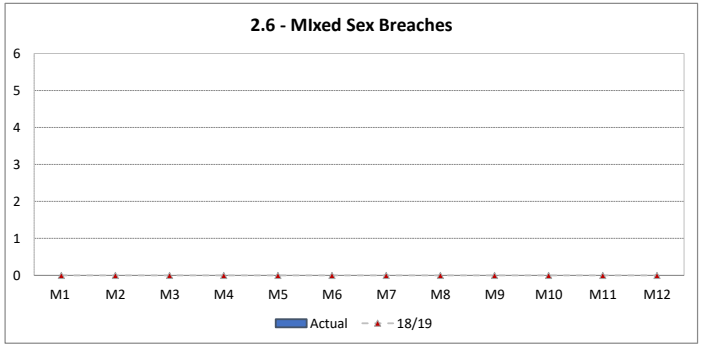












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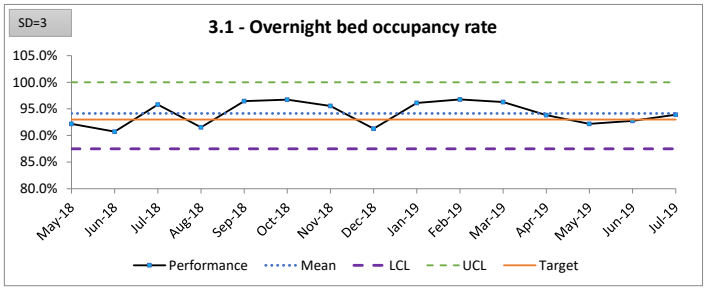
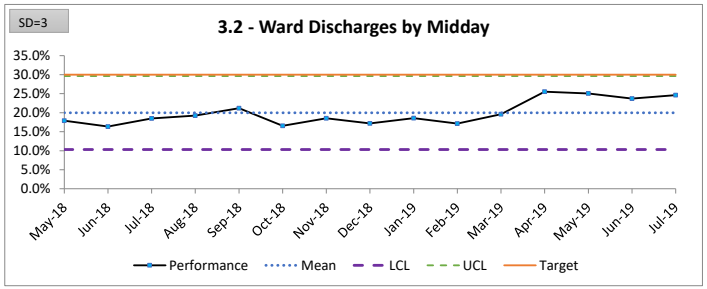
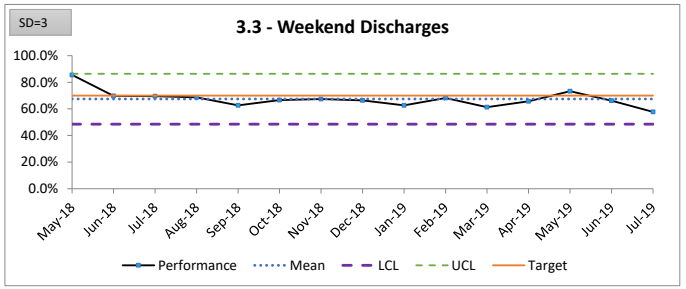
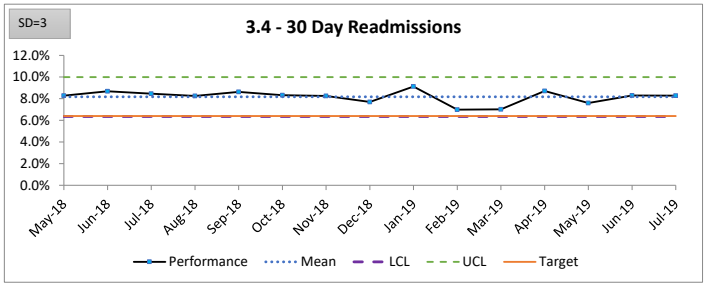
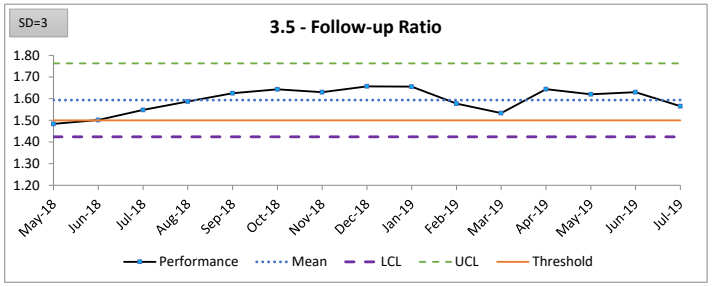
OBJECTIVE 3 - CLINICAL EFFECTIVENESS

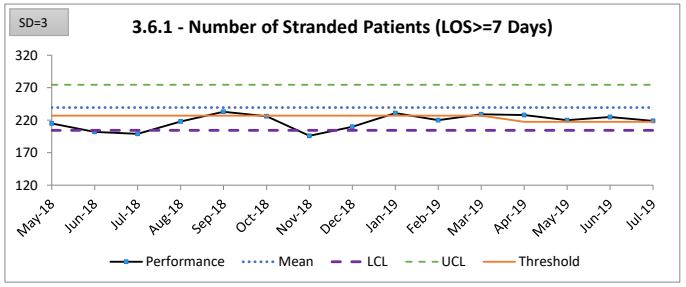


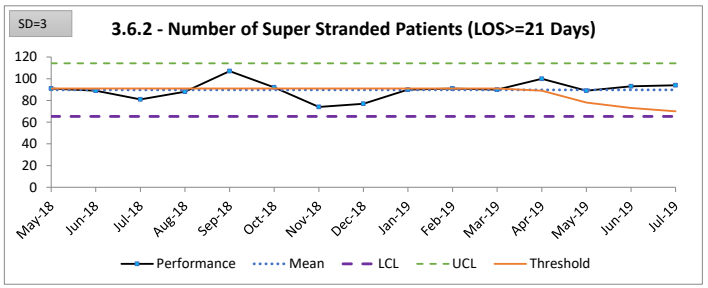


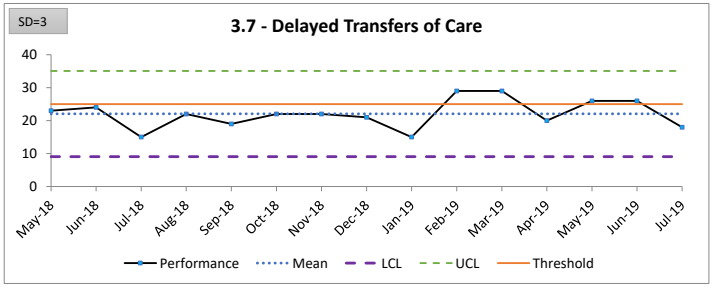


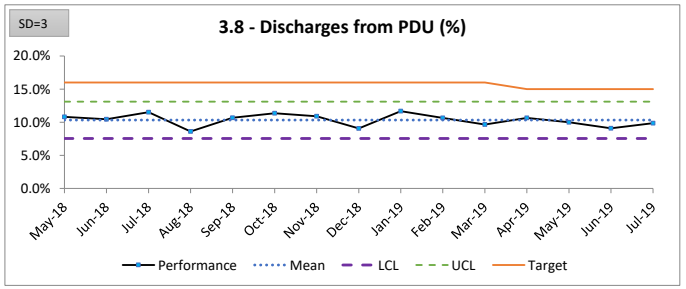


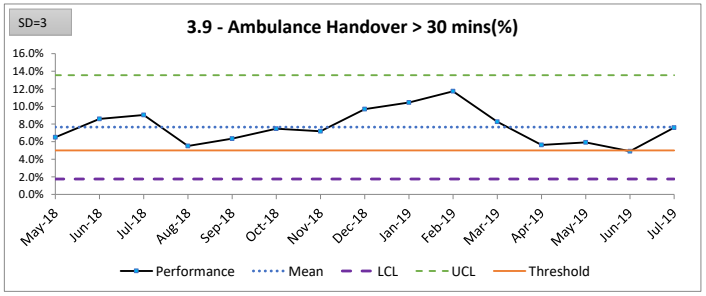












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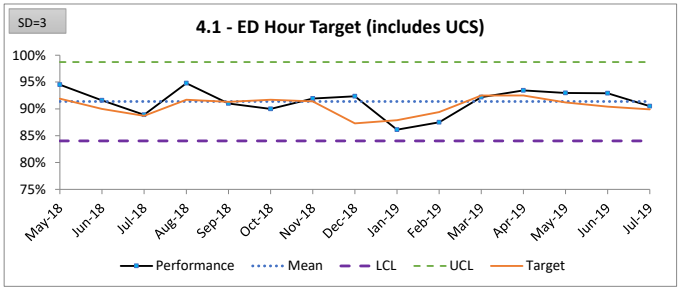
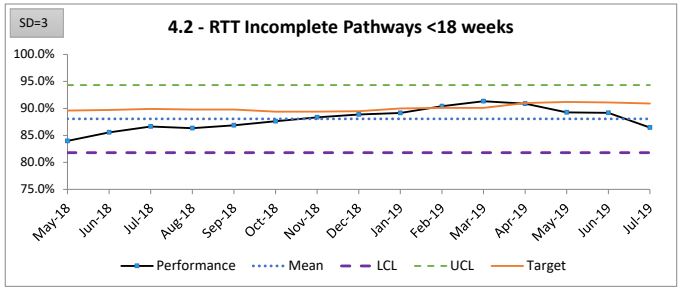
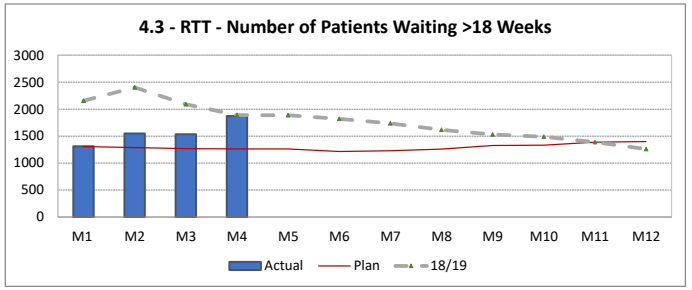
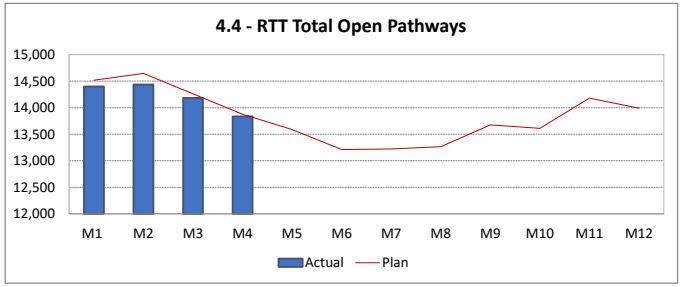
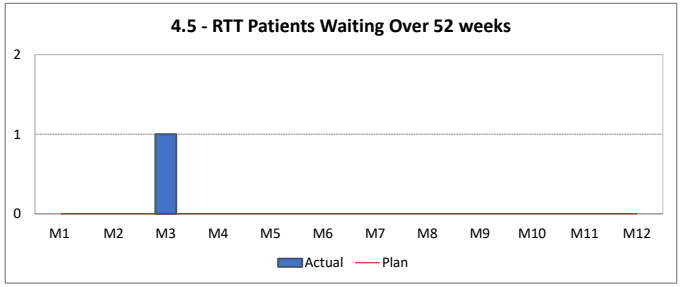
OBJECTIVE 4 - KEY TARGETS

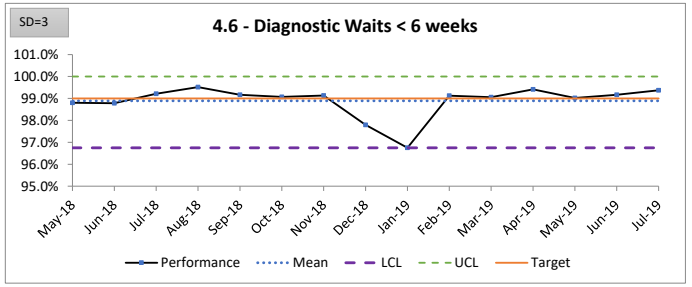


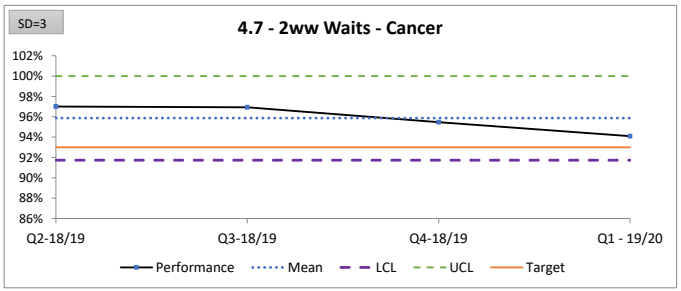


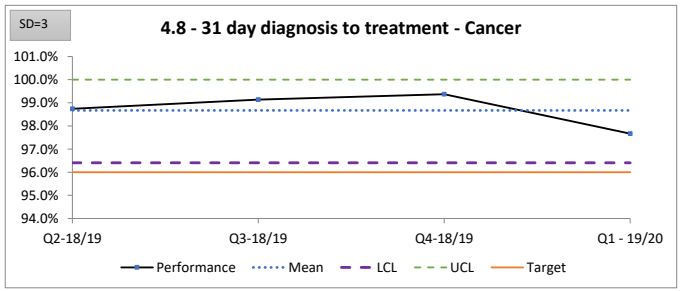


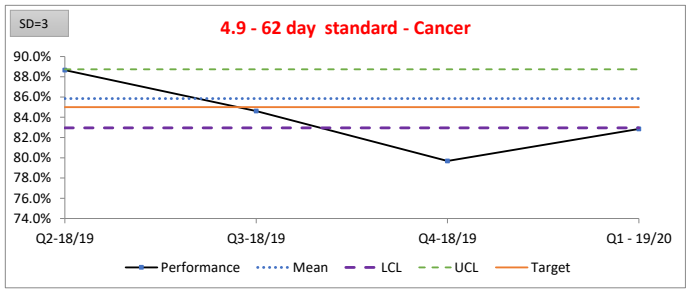












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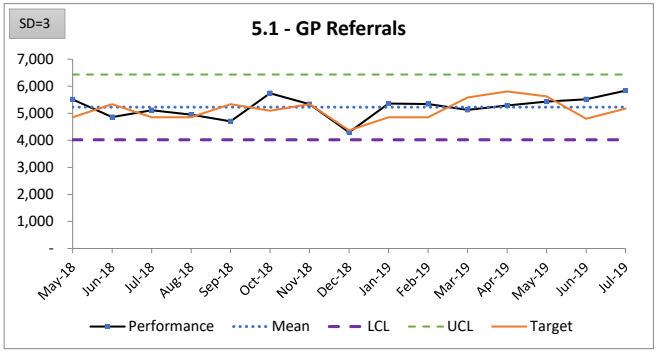
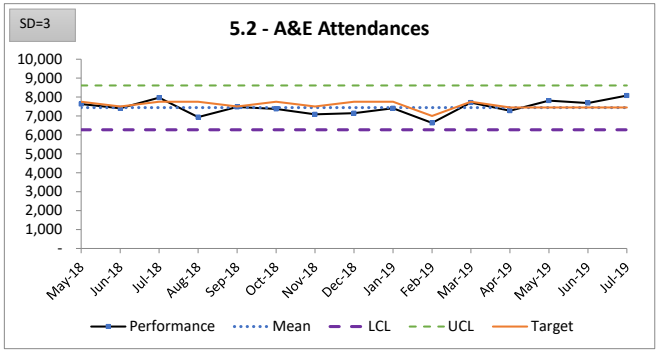
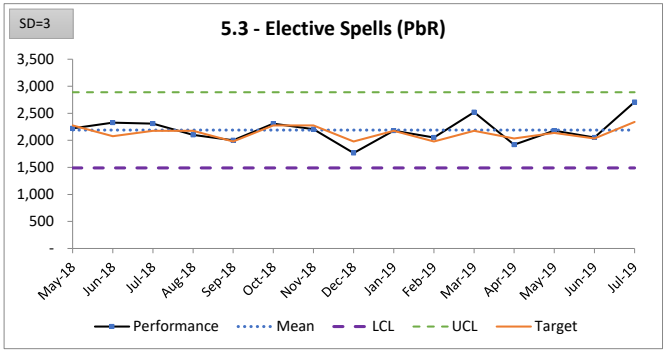
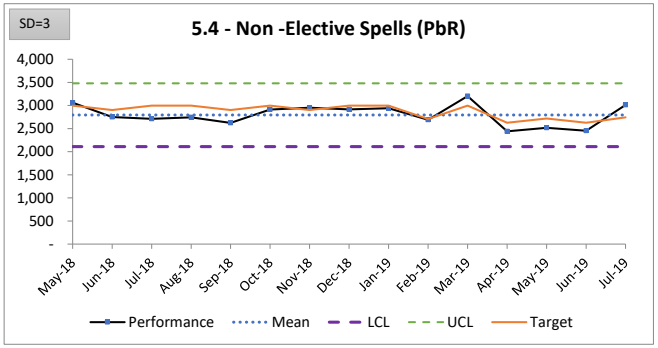
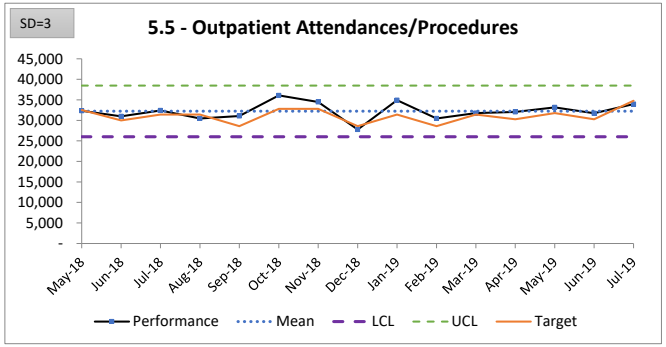
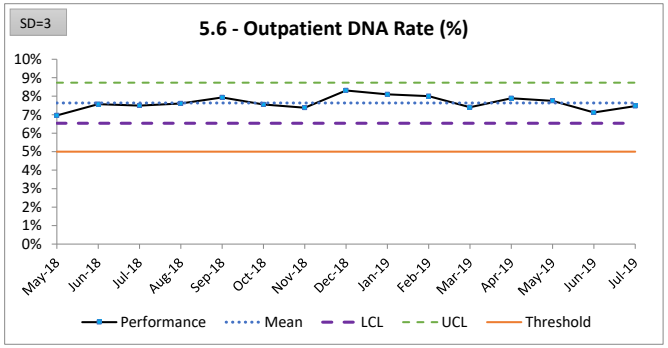






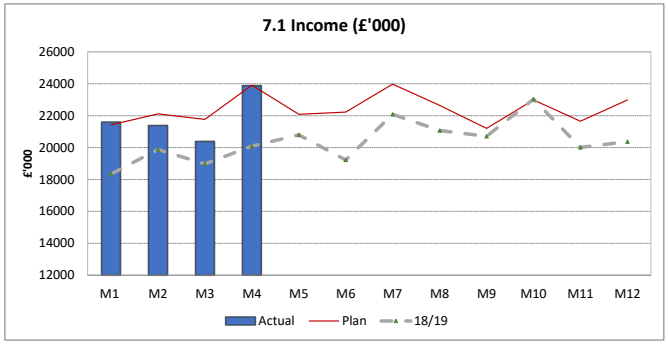


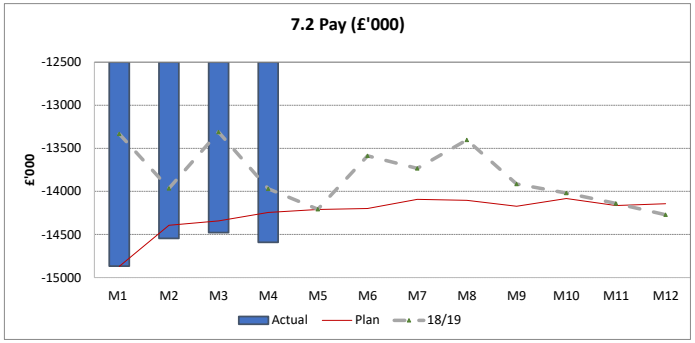


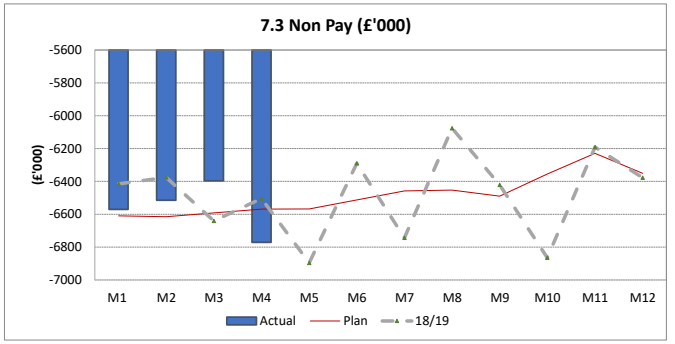


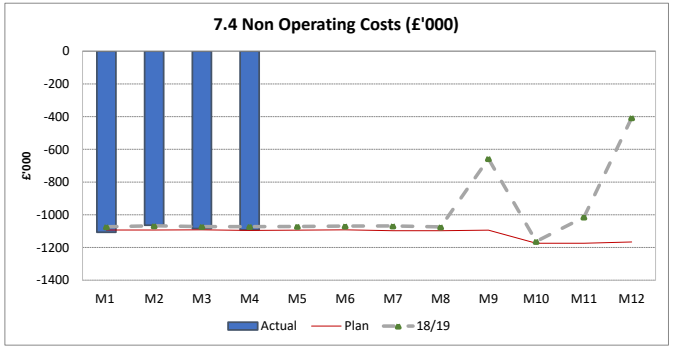
If the LCL is negative (less than zero) it is set to zero.
If the UCL is greater than 100% it is set to 100%.

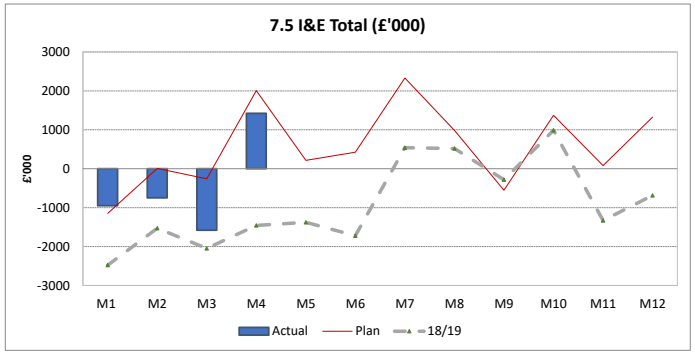
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

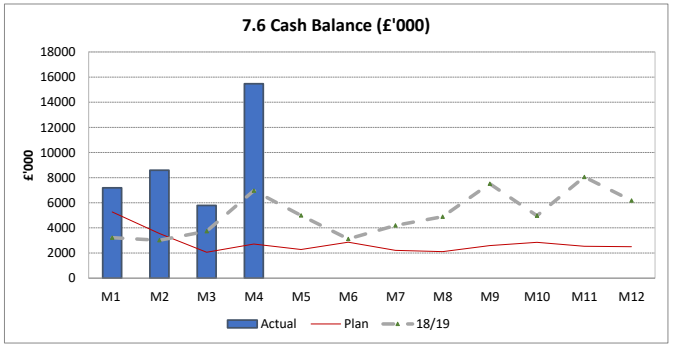

7.1 Income (£'000)
£'000
26000
24000
22000
20000
18000
16000
14000
12000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

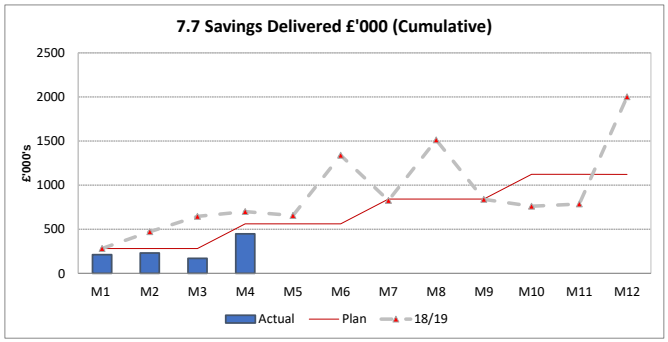

7.2 Pay (£'000)
£'000
-12500
-13000
-13500
-14000
-14500
-15000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

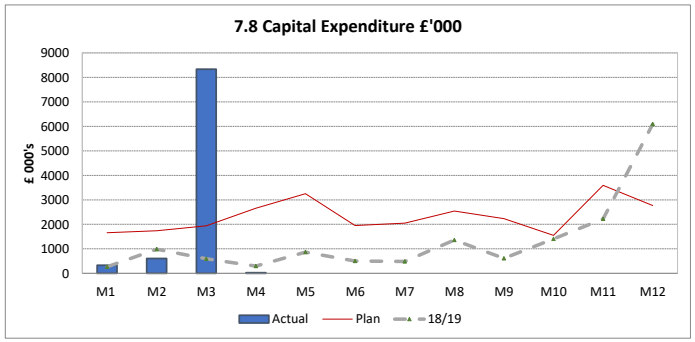

7.3 Non Pay (£'000)
(£'000)
-5600
-5800
-6000
-6200
-6400
-6600
-6800
-7000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

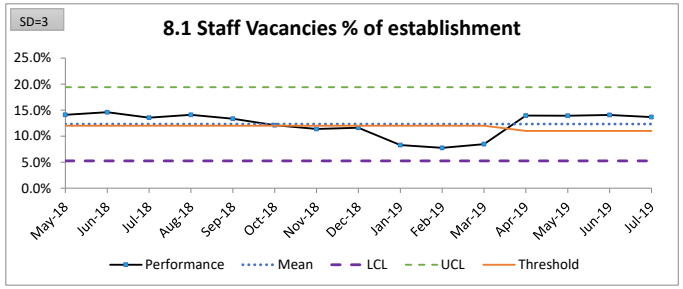

7.4 Non Operating Costs (£'000)
£'000
0
-200
-400
-600
-800
-1000
-1200
-1400
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

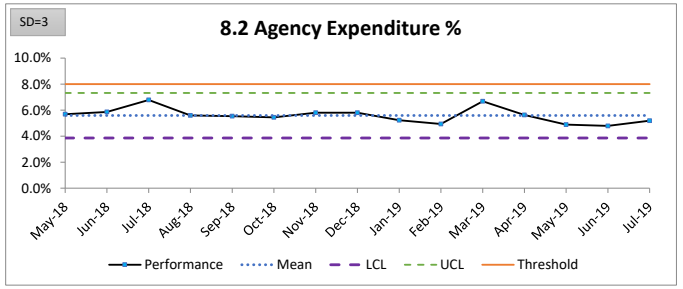

7.5 I&E Total (£'000)
£'000
3000
2000
1000
0
-1000
-2000
-3000
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

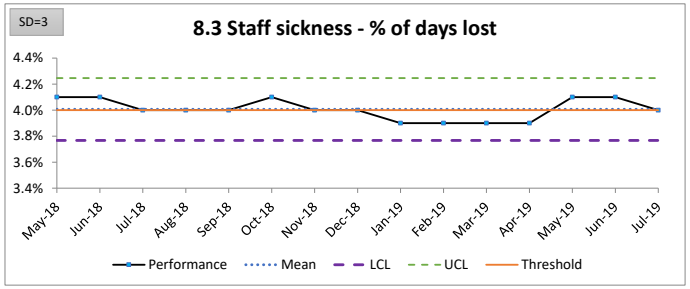

7.6 Cash Balance (£'000)
£'000
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

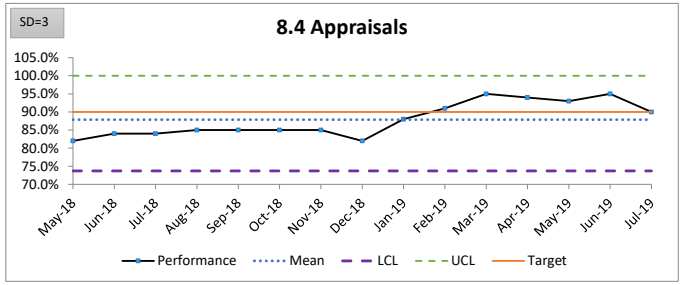

7.7 Savings Delivered £'000 (Cumulative)
£'000's
2500
2000
1500
1000
500
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

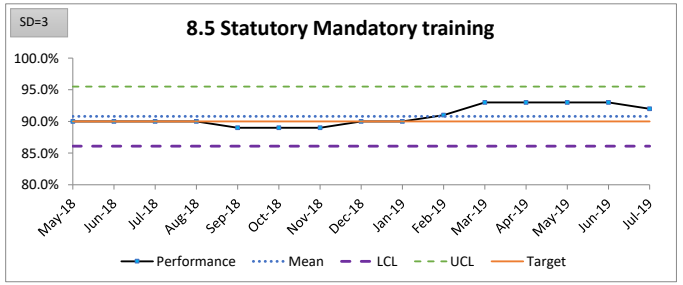

7.8 Capital Expenditure £'000
£ 000's
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Actual
Plan
18/19

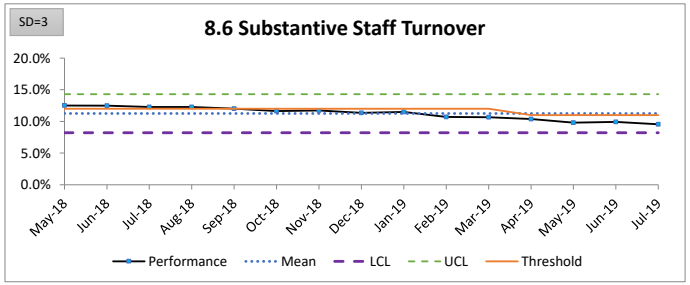












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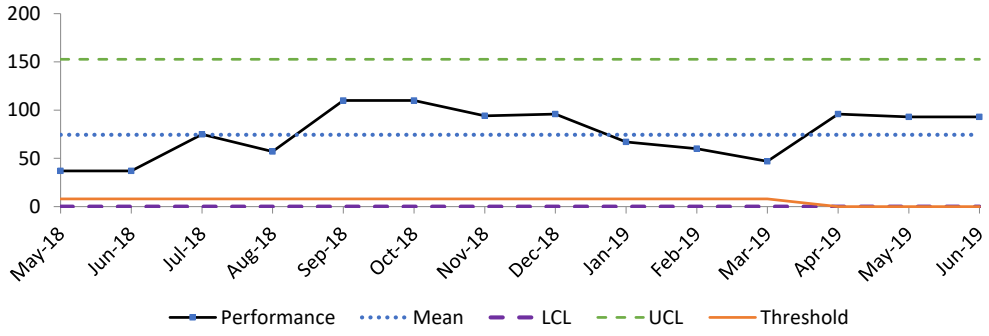
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

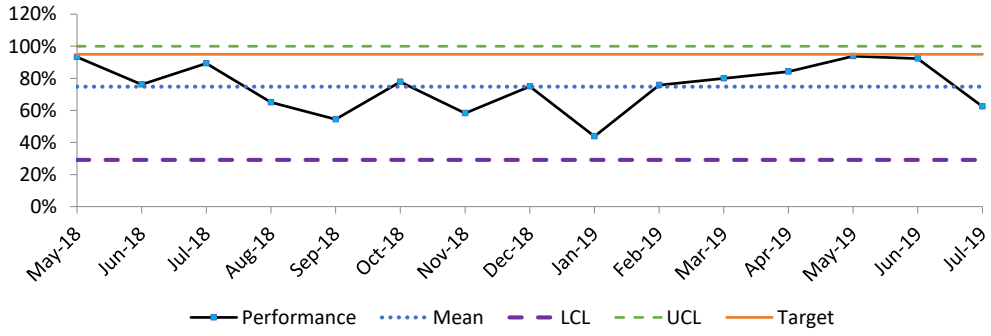
SD=3

O.1 - Total Number OF Nice Breaches

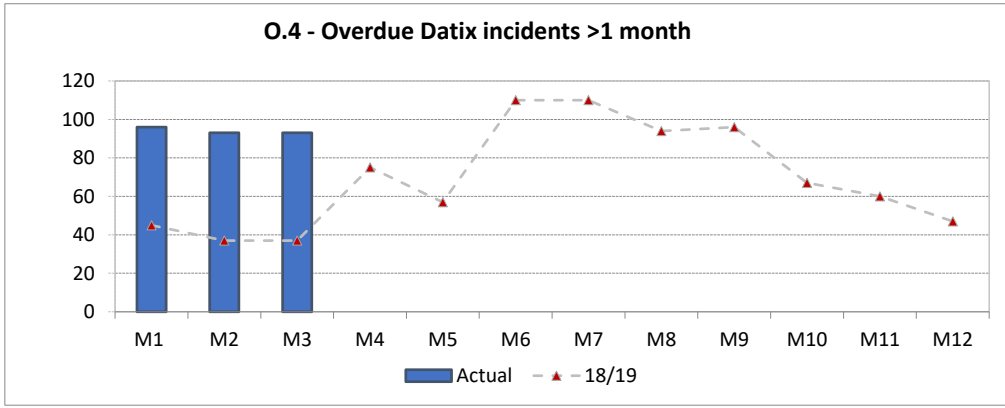


SD=3

O.2 - Rebooked cancelled OPs - 28 day rule

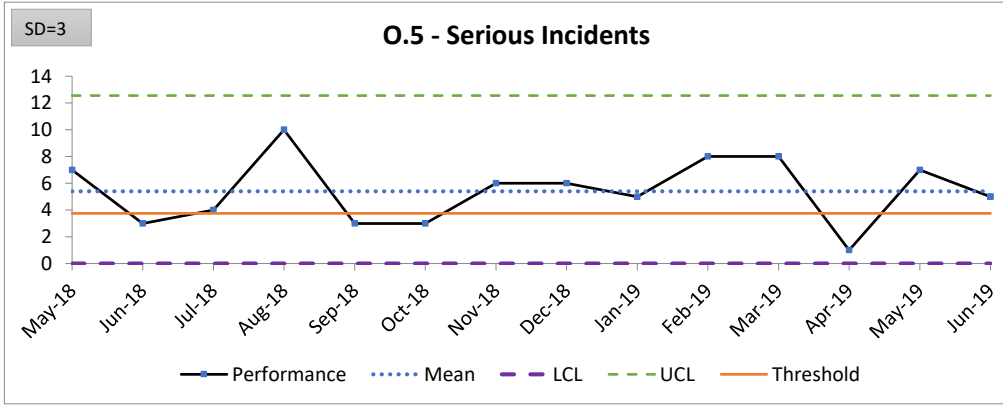


O.4 - Overdue Datix incidents >1 month



SD=3

O.5 - Serious Incidents



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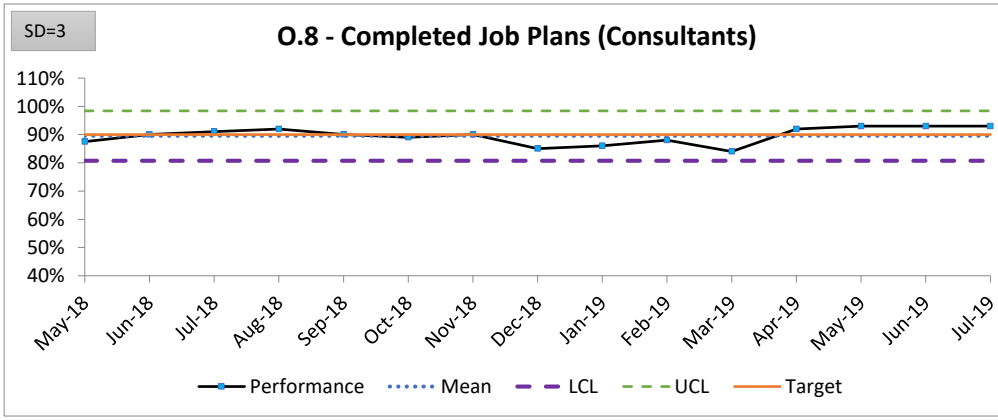
- Performance activity on a rolling 12 months/quarterly
- Average on a rolling 12 months/quarterly
- Lower Control Limit (LCL)
- Upper Control Limit
- Targets/Thresholds/NHSI Trajectories

SD=3

O.8 - Completed Job Plans (Consultants)



Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Public Board	Date: 5 September 2019
Report title:	**Finance Paper Month 4 2019-20**	**Agenda item: 4.2**
Lead director **Report authors**	Mike Keech Daphne Thomas Chris Panes	Director of Finance Deputy Director of Finance Head of Management Accounts
FoI status:	Private document	

Report summary	**An update on the financial position of the Trust at Month 4 (July 2019)**			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** X	**Decision** ☐
Recommendation	Trust Board to note the contents of the paper.			

Strategic objectives links	5. Developing a Sustainable Future 7. Become Well-Governed and Financially Viable 8. Improve Workforce Effectiveness
Board Assurance Framework links	
CQC outcome/ regulation links	Outcome 26: Financial position
Identified risks and risk management actions	
Resource implications	See paper for details
Legal implications including equality and diversity assessment	This paper has been assessed to ensure it meets the general equality duty as laid down by the Equality Act 2010

Report history	None
Next steps	None
Appendices	1 to 3

FINANCE REPORT FOR THE MONTH TO 31st JULY 2019

PUBLIC BOARD MEETING

PURPOSE

1. The purpose of the paper is to:

    - Present an update on the Trust's latest financial position covering income and expenditure; cash, capital and liquidity; NHSI financial risk rating; and cost savings; and
    - Provide assurance to the Finance & Investment Committee that actions are in place to address any areas where the Trust's financial performance is adversely behind plan at this stage of the financial year.

EXECUTIVE SUMMARY

2. *Income and expenditure* –The Trust's surplus for July 2019 was £1.4m which is £0.6m adverse to budget in the month and £2.1m adverse YTD. However, at control total level (excluding PSF/FRF/MRET & donations) the position is more favourable with a £0.1m adverse variance on a YTD basis.

3. Cash and capital position – the cash balance as at the end of July 2019 was £15.5m, which was £12.7m above plan due to the timing of capital expenditure and receipts from prior year PSF funding. The Trust has spent £9.3m on capital up to month 4 of which £0.7m relates to ECare, £6.1m cancer centre, £0.3m GDE, £0.3 North site infrastructure, £0.2m on design works for new strategic projects and £1.6m on patient safety and clinically urgent capital expenditure.

4. *NHSI rating – the Use of Resources rating (UOR) score is '3', which* is in line with Plan, with '4' being the lowest scoring.

5. *Cost savings* – overall savings of £0.4m were delivered in month against an identified plan of £0.4m and the target of £0.6m. YTD £1.1m has been delivered against a plan of £1.1m and a target of £1.8m. As at month 4, £3.5m of schemes have been validated and added to the tracker against the full year £8.4m target.

INCOME AND EXPENDITURE

6. The headline financial position can be summarised as follows:

All Figures in £'000	Month 4 Plan	Month 4 Actual	Month 4 Var	Month 4 YTD Plan	Month 4 YTD Actual	Month 4 YTD Var	Full Year Plan	Full Year Forecast	Full Year Var
Clinical Revenue	19,278	19,325	47	73,058	72,910	(148)	218,726	218,726	0
Other Revenue	1,607	2,014	407	6,467	7,116	649	19,085	19,085	0
Total Income	20,885	21,339	455	79,525	80,026	501	237,811	237,811	0
Pay	(14,245)	(14,591)	(346)	(57,857)	(58,482)	(625)	(171,023)	(171,023)	0
Non Pay	(6,551)	(6,771)	(220)	(26,307)	(26,313)	(6)	(77,808)	(77,808)	0
Total Operational Expend	(20,796)	(21,362)	(566)	(84,164)	(84,795)	(631)	(248,831)	(248,831)	0
EBITDA	89	(22)	(111)	(4,638)	(4,768)	(130)	(11,020)	(11,020)	0
Financing & Non-Op. Costs	(1,048)	(1,036)	11	(4,190)	(4,123)	67	(12,570)	(12,570)	0
Control Total Deficit (excl. PSF)	**(958)**	**(1,058)**	**(100)**	**(8,828)**	**(8,892)**	**(63)**	**(23,590)**	**(23,590)**	**0**
Adjustments excl. from control total:									
PSF	280	280	0	910	1,382	472	4,197	4,197	0
PSF- ICS	61	0	(61)	199	0	(199)	923	923	0
FRF	987	987	0	3,208	3,208	0	14,807	14,807	0
MRET	270	270	0	1,079	1,079	0	3,237	3,237	0
Control Total Deficit (incl. PSF)	**640**	**479**	**(161)**	**(3,432)**	**(3,223)**	**210**	**(426)**	**(426)**	**0**
Donated income	1,441	1,000	(441)	4,311	2,000	(2,311)	8,000	8,000	0
Donated asset depreciation	(66)	(56)	9	(262)	(225)	37	(786)	(786)	0
Reported deficit/surplus	**2,015**	**1,422**	**(593)**	**617**	**(1,448)**	**(2,064)**	**6,788**	**6,788**	**0**

Monthly and year to date review

7. The **deficit excluding central funding (PSF, FRF and MRET) and donated income** in month 4 is £1,119k which is £100k adverse to plan in month and £63k adverse YTD. For M4 the Trust recognised the loss of income of £61k (£199k YTD) due to the financial performance of the ICS. The total central funding allocation recognised in the position is £1,537k (£5,669k YTD).

8. The Trust reported a surplus in month 4 of £1,422k which is £593k adverse to the budget deficit of £2,015k which was mainly driven by a negative variance against plan on donated income relating to the Cancer Centre.

9. **Income (excluding PSF/FRF/MRET and donations effect)** is £455k favourable to plan in July and £501k favourable YTD and can be further analysed in Appendix 1

10. **Operational costs** in July are adverse to plan by £566k in month and adverse by £631k YTD.

11. **Pay costs** are £346k adverse to budget in Month 4. Substantive pay has slightly decreased in month but remains high with the use of additional sessions. Bank expenditure has increased

from M3 and is significantly above budgeted levels. Negative variances against bank are offset by positive variances against agency.

12. **Non-pay costs** were £220k adverse to plan in month and £6k adverse YTD. Negative variances against education & training expenses, premises & fixed plant and general supplies are offset by positive variances against miscellaneous operating expenses, high cost drugs and clinical supplies. The high expenditure within premises and fixed plant is driven by expenditure on minor works, computer software purchase and maintenance.

13. **Non-operational costs** are marginally favourable in month due to variances on depreciation

COST SAVINGS

14. In Month 4, £441k was delivered against an identified plan of £447k and a target of £562k. YTD £1,052k has been delivered against a plan of £1,047k and a target of £1,825k.

15. Previously opportunities for the full year £8.4m target had been identified, however these are under review to understand the implications of the guaranteed income contract with MKCCG. Currently £3,535k of plans have been validated and added to the tracker.

CASH AND CAPITAL

16. The cash balance at the end of July 2019 was £15.5m, which was £12.7m above plan due to the timing of capital expenditure and receipts from prior year PSF funding.

17. The **statement of financial position** is set out in Appendix 3. The main movements and variance to plan can be summarised as follows:

- Non-Current Assets are below plan by £26.9m; this is mainly driven by the revaluation of the Trust estate in 2018/19 and timing of capital projects.

- Current assets are above plan by £12.7m, this is due to cash £12.8m and inventories £0.4m above plan offset by receivables £0.5m below plan. See Appendix 12 and Appendix 13 for further debtor details.

- Current liabilities are below plan by £9.3m. This is being driven by Trade and Other Creditors £6.5m, deferred income £2.6m and provisions £0.2m above plan.

- Non-Current Liabilities are below plan by £0.9m. This is being driven by provisions £0.3m and borrowings £0.6m below plan.

18. The Trust has spent £9.3m on capital up to month 3 of which £0.7m relates to ECare, £6.1m cancer centre, £0.3m GDE, £0.3 North site infrastructure, £0.2m on design works for new strategic projects and £1.6m on patient safety and clinically urgent capital expenditure.

RISK REGISTER

19. The following items represent the finance risks on the Board Assurance Framework and a brief update of their current position:

a) Constraints on the NHS Capital Expenditure Limit may lead to delays in the Trust receiving its required capital funding or other restrictions being placed on the Trust's capital programme.

The Trust is awaiting further guidance on the extent to which current capital plans are affordable and is liaising with its partners in the Integrated Care System to consider options to reduce the system capital requirement.

b) There is a risk that the Trust does not receive timely confirmation that its revenue loans due for repayment in 2019/20 have been refinanced.

Funding to cover the ongoing funding requirements in 2019/20 is subject to approval by DHSC on a monthly basis and remains a risk in the new financial year. As in previous years the Trust will liaise with NHS Improvement in respect of revenue loans due for repayment in 2019/20.

c) The Trust is unable to achieve the required levels of financial efficiency within the Transformation Programme.

The Trust has a target of £8.4m of which all will need to be delivered through cost reduction, this remains a risk to meeting the Trust's year end control total.

d) The Trusts guaranteed income contract may not deliver the benefits expected and leads to unfunded activity

If the Trust cannot adopt new models of care and reduce levels of activity into the Trust the may be an opportunity cost to the trust in which it delivers significant amounts of unfunded activity at a high cost to the Trust.

RECOMMENDATIONS TO BOARD OF DIRECTORS

20. The Trust Board is asked to note the financial position of the Trust as at 31st July 2019 and the proposed actions and risks therein.

Appendix 1

Milton Keynes Hospital NHS Foundation Trust
Statement of Comprehensive Income
For the period ending 31st July 2019

	July 2019			4 months to July 2019			Full year
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Outpatients	4,122	4,252	130	15,055	15,309	254	45,166
Elective admissions	2,640	2,517	(124)	9,643	9,398	(246)	28,930
Emergency admissions	6,274	5,984	(290)	24,630	22,816	(1,813)	73,498
Emergency adm's marginal rate (MRET)	(276)	(265)	11	(1,085)	(1,042)	43	(3,238)
Readmissions Penalty	(279)	(279)	0	(1,118)	(1,118)	0	(3,353)
A&E	1,202	1,325	124	4,806	5,112	306	14,418
Maternity	1,687	1,901	214	6,682	7,352	670	19,980
Critical Care & Neonatal	581	462	(119)	2,121	1,851	(269)	6,362
Excess bed days	0	0	0	0	0	0	0
Imaging	461	468	7	1,684	1,870	186	5,053
Direct access Pathology	431	424	(7)	1,575	1,613	37	4,726
Non Tariff Drugs (high cost/individual drugs)	1,788	1,741	(48)	6,532	6,065	(467)	19,488
Other	646	794	148	2,533	3,684	1,151	7,695
Clinical Income	**19,278**	**19,325**	**47**	**73,058**	**72,910**	**(148)**	**218,726**
Non-Patient Income	**4,646**	**4,551**	**(95)**	**16,174**	**14,785**	**(1,389)**	**50,249**
TOTAL INCOME	**23,924**	**23,876**	**(47)**	**89,232**	**87,695**	**(1,537)**	**268,975**
EXPENDITURE							
Total Pay	**(14,245)**	**(14,591)**	**(346)**	**(57,857)**	**(58,482)**	**(625)**	**(171,023)**
Non Pay	(4,763)	(5,030)	(267)	(19,775)	(20,248)	(473)	(58,320)
Non Tariff Drugs (high cost/individual drugs)	(1,788)	(1,741)	48	(6,532)	(6,065)	467	(19,488)
Non Pay	**(6,551)**	**(6,771)**	**(220)**	**(26,307)**	**(26,313)**	**(6)**	**(77,808)**
TOTAL EXPENDITURE	**(20,796)**	**(21,362)**	**(566)**	**(84,164)**	**(84,795)**	**(631)**	**(248,831)**
EBITDA*	**3,128**	**2,515**	**(613)**	**5,069**	**2,901**	**(2,168)**	**20,144**
Depreciation and non-operating costs	(983)	(962)	21	(3,932)	(3,827)	105	(11,796)
OPERATING SURPLUS/(DEFICIT) BEFORE DIVIDENDS	**2,145**	**1,553**	**(592)**	**1,137**	**(928)**	**(2,063)**	**8,349**
Public Dividends Payable	(130)	(130)	(0)	(520)	(521)	(1)	(1,560)
OPERATING DEFICIT AFTER DIVIDENDS	**2,015**	**1,422**	**(593)**	**617**	**(1,449)**	**(2,064)**	**6,788**
Adjustments to reach control total							
Donated Income	(1,441)	(1,000)	441	(4,311)	(2,000)	2,311	(8,592)
Donated Assets Depreciation	66	56	(9)	262	225	(37)	697
Control Total Rounding	0	0	0	0	0	0	0
PSF	(1,598)	(1,538)	61	(5,397)	(5,670)	(273)	(10,263)
CONTROL TOTAL DEFECIT	**(959)**	**(1,059)**	**(101)**	**(8,829)**	**(8,893)**	**(63)**	**(11,370)**

* EBITDA = Earnings before Interest, Taxation, Depreciation and Amortisation

Appendix 2

Milton Keynes Hospital NHS Foundation Trust
Statement of Cash Flow
As at 31st July 2019

	Mth 4 £000	Mth 3 £000	In Month Movement £000
Cash flows from operating activities			
Operating (deficit) from continuing operations	(194)	(1,929)	1,735
Operating surplus/(deficit) of discontinued operations			
Operating (deficit)	**(194)**	**(1,929)**	**1,735**
Non-cash income and expense:			
Depreciation and amortisation	3,096	2,314	782
Impairments	0	0	0
(Increase)/Decrease in Trade and Other Receivables	7,680	(409)	8,089
(Increase)/Decrease in Inventories	7	6	1
Increase/(Decrease) in Trade and Other Payables	2,761	4,307	(1,546)
Increase/(Decrease) in Other Liabilities	2,498	1,743	755
Increase/(Decrease) in Provisions	(15)	(14)	(1)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	(2,000)	(1,000)	(1,000)
Other movements in operating cash flows	0	0	0
NET CASH GENERATED FROM OPERATIONS	**13,833**	**5,018**	**8,815**
Cash flows from investing activities			
Interest received	29	21	8
Purchase of financial assets	(175)	(175)	0
Purchase of intangible assets	(944)	(191)	(753)
Purchase of Property, Plant and Equipment, Intangibles	(7,701)	(7,910)	209
Sales of Property, Plant and Equipment			0
Net cash generated (used in) investing activities	**(8,791)**	**(8,255)**	**(536)**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Loans received from Department of Health	2,915	2,315	600
Loans repaid to Department of Health	(159)	(159)	0
Capital element of finance lease rental payments	(43)	(40)	(3)
Interest paid	(364)	(198)	(166)
Interest element of finance lease	(95)	(73)	(22)
PDC Dividend paid	0	0	0
Receipt of cash donations to purchase capital assets	2000	1000	1,000
Cash flows from (used in) other financing activities	0	0	0
Net cash generated from/(used in) financing activities	**4,254**	**2,845**	**1,409**
Increase/(decrease) in cash and cash equivalents	**9,296**	**(392)**	9,688
Opening Cash and Cash equivalents	**6,175**	**6,175**	0
Closing Cash and Cash equivalents	**15,471**	**5,783**	**9,688**

Appendix 3

Milton Keynes Hospital NHS Foundation Trust
Statement of Financial Position as at 31st July 2019

	Audited Mar-19	Jul-19 YTD Plan	Jul-19 YTD Actual	In Mth Mvmt	YTD Mvmt	% Variance
Assets Non-Current						
Tangible Assets	147.3	182.7	153.3	(29.4)	6.0	4.1%
Intangible Assets	14.2	12.3	14.5	2.2	0.3	2.1%
Other Assets	0.5	0.3	0.6	0.3	0.1	31.0%
Total Non Current Assets	**162.0**	**195.3**	**168.4**	**(26.9)**	**6.4**	**4.0%**
Assets Current						
Inventory	3.6	3.2	3.6	0.4	0.0	0.0%
NHS Receivables	23.5	18.3	14.0	(4.3)	(9.5)	(40.4%)
Other Receivables	6.0	4.0	7.8	3.8	1.8	30.0%
Cash	6.2	2.7	15.5	12.8	9.3	150.0%
Total Current Assets	**39.3**	**28.2**	**40.9**	**12.7**	**1.6**	**4.1%**
Liabilities Current						
Interest -bearing borrowings	(80.2)	(82.9)	(82.9)	0.0	(2.7)	3.4%
Deferred Income	(1.7)	(1.6)	(4.2)	(2.6)	(2.5)	146.2%
Provisions	(1.6)	(1.4)	(1.6)	(0.2)	(0.0)	2.0%
Trade & other Creditors (incl NHS)	(28.9)	(26.2)	(32.7)	(6.5)	(3.8)	13.2%
Total Current Liabilities	**(112.3)**	**(112.1)**	**(121.4)**	**(9.3)**	**(9.1)**	8.1%
Net current assets	**(73.0)**	**(83.9)**	**(80.5)**	**3.4**	**(7.5)**	**10.2%**
Liabilities Non-Current						
Long-term Interest bearing borrowings	(53.0)	(54.0)	(53.4)	0.6	(0.4)	0.7%
Provisions for liabilities and charges	(0.8)	(1.1)	(0.8)	0.3	0.0	0.0%
Total non-current liabilities	**(53.9)**	**(55.1)**	**(54.2)**	**0.9**	**(0.4)**	0.7%
Total Assets Employed	**35.1**	**56.3**	**33.7**	**(23.0)**	**(1.4)**	**(4.0%)**
Taxpayers Equity						
Public Dividend Capital (PDC)	101.4	101.8	101.3	(0.5)	(0.1)	-0.1%
Revaluation Reserve	58.3	78.7	58.3	(20.4)	0.0	0.0%
I&E Reserve	(124.5)	(124.2)	(125.9)	(1.7)	(1.4)	1.1%
Total Taxpayers Equity	**35.1**	**56.3**	**33.7**	**(22.6)**	**(1.5)**	**(4.1%)**

Meeting title	**Trust Board**	**Date: 5 September 2019**
Report title:	**Workforce report**	**Agenda item: 4.3**
Lead director **Report author**	**Name: Danielle Petch** **Name: Paul Sukhu**	**Title: Director of Workforce** **Title: Deputy Director of Workforce**
FoI status:		

Report summary	This report provides a summary of workforce Key Performance Indicators for the full year ending 31 July 2019 (Month 4).			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [x]	**Decision** [ ]
Recommendation	Trust Board is asked to note the Workforce report and to approve the 2019/20 aspirational agency target of £9.7m			

Strategic objectives links	Objective 8 : Improve Workforce Effectiveness
Board Assurance Framework links	None
CQC outcome/ regulation links	Well Led Outcome 13 : Staffing
Identified risks and risk management actions	1606 - We may be unable to recruit sufficient qualified nurses for safe staffing in wards and departments 1608 - There is a risk that sufficient numbers of employees may not undergo an appraisal to achieve target of 90%. 1609 - IF staff are unable to remain compliant in all aspects of mandatory training linked to their job requirements THEN staff may not have the knowledge and skills required for their role LEADING potential patient/staff safety risk and inability to meet CCG compliance target of 90% 1613 - IF there is inability to retain staff employed in critical posts THEN we may not be able to provide safe workforce cover LEADING TO clinical risk.
Resource implications	
Legal implications including equality and diversity assessment	

Report history	Full monthly Corporate Workforce Information report - Executive Management Board, Divisional Accountability, August 2019
Next steps	
Appendices	Appendix 1 – Flu campaign uptake 2018/19.

Workforce report – Month 4, 2019/20

1. Purpose of the report

1.1. This report provides a summary of workforce Key Performance Indicators for the full year ending 31 July 2019 (Month 4).

2. Staff in post

2.1. The Trust's staff in post by whole time equivalent (WTE) was 3079.1 as at 31 July 2019; an increase of 36.6 WTE since July 2018.

2.2. The Trust's headcount is 3563, an increase of 39 since July 2018.

2.3. The largest increases of staff in post since July 2018 have been in the Nursing and Midwifery and Estates and Ancillary staff groups.

3. Vacancy rate

3.1. The Trust's overall vacancy rate is 11.7%; this has reduced from 12.9% in April 2019 (M1).

3.2. In line with the Trust's Workforce Strategy, the Divisional HR Business Partners are currently working with Finance and Clinical Divisional colleagues to formulate plans to reduce actual vacancies in their establishments on a line-by-line basis and by use of overarching strategies.

3.3. This critical work is likely to impact upon temporary staffing expenditure, and in the coming months, time spent on recruitment activities will increase significantly for Recruiting Managers and the Trust's Recruitment team.

3.4. In terms of outputs, the Trust may not see the full impact of this work until towards the end of 2019/20 as vacancies start to be filled.

4. Turnover

4.1. The Trust's leaver turnover rate was lower throughout 2018/19 than it was in 2017/18 and this trend has continued into 2019/20. The M4 position is further reduced to 9.7%.

4.2. The Trust's turnover rate has continued to improve in the wake of ongoing engagement work in respect of Staff Benefits and the NHS Staff Survey engagement activities.

5. Temporary Staffing and Aspirational Agency Target

5.1. The temporary staff usage (bank and agency) for the rolling year-to-date was 6073.9 WTE, which was 14.5% of total WTE staff employed.

5.2. Agency staff usage was 3.6% of the total WTE staff employed for the rolling year to date but was 5.6% of the total annual staff expenditure. This is predominantly driven by high cost Medical and Dental agency locums and volume of Nursing agency staff where comparative vacancy rates are above 14%.

5.3. Detailed analysis of bank and agency expenditure has been undertaken to target interventions for greater effect as the Trust seeks to reduce its reliance on temporary staffing into 2019/20. Led by the HR Business Partners, the Clinical Divisions have devised plans to reduce areas of high cost and/or volume of agency expenditure through renewed and targeted recruitment campaigns.

5.4. In 2018/19 the Trust was set an agency ceiling (a limit for spend on agency temporary staffing) of £11.4m by NHS Improvement. Following the introduction of new agency controls and active steps taken to reduce agency spend, the Trust was able come in significantly under the agency ceiling with a total spend of £9.7m for the year.

5.5. Recognising the increasing pressures on staffing, the Trust's agency ceiling for 2019/20 has been set at £11.1m; while this represents an increase on actual spend in 2018/19, the new ceiling recognises that regionally agency costs have been increasing.

5.6. The Trust has an excellent track record over recent years of managing its agency spend (having reduced total spend from £21m at its peak in 2016/17) and therefore, despite the pressures, the Trust plans to set a stretching but achievable target of £9.7m of agency spend in 2019/20 (thereby maintaining spend at 2018/19 levels). This would represent a (£1.4m) 13% improvement against the NHSI agency ceiling.

5.7. The Board is therefore asked to approve a 2019/20 aspirational agency target of £9.7m.

6. Sickness absence

6.1. The sickness absence rate (N.B. 12 months to M3, 30 June 2019) has increased to 4.04% against the Trust target of 4.0% (1.71 % short term and 2.33% long term).

6.2. Overall, the Trust's sickness absence levels remain lower than the same period for the last two financial years.

6.3. In July 2019, Workforce Board agreed to remove the 'Unknown' reason for absence from the manager entry screens of the HealthRoster system, to reduce the number of 'Unknown' episodes recorded. It is anticipated that this will increase the episodes of the absence reasons in the highest-ranking absence causes but the Trust will be better able to support interventions for colleagues where their absences are appropriately coded.

6.4. More detail on sickness absence is reported and discussed at Divisional Executive Management Board (Divisional Accountability – monthly), Workforce Board and Workforce and Development Assurance Committee (both quarterly).

7. Statutory and mandatory training

7.1. Statutory and mandatory training compliance as at 31 July 2019 was at 92% against the Trust target of 90%.

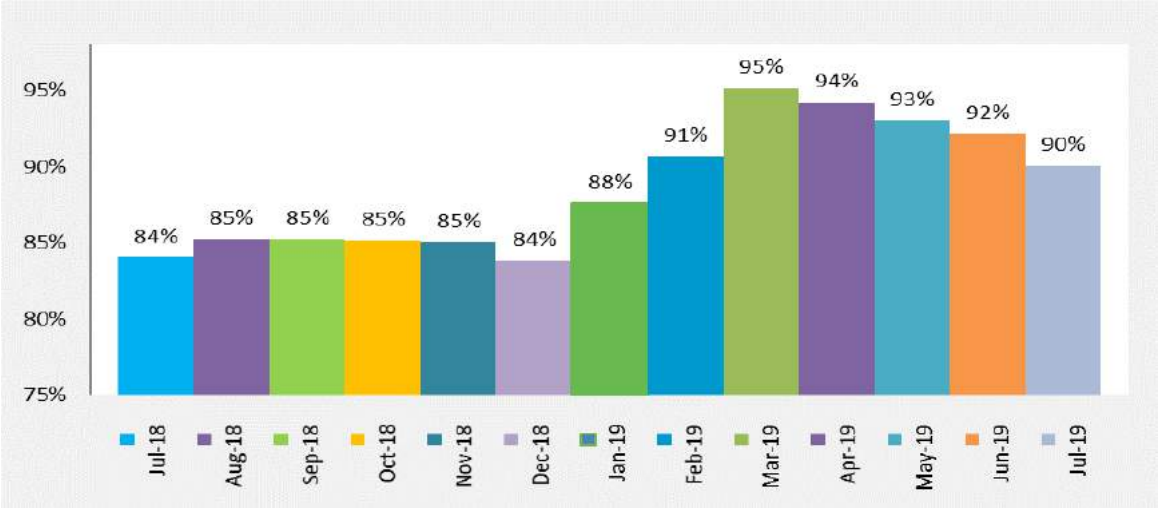
Training Compliance by Division	
Core Clinical	94%
Corporate Services	94%
Medicines Unplanned Care	91%
Surgical Planned Care	90%
Women's and Children's	92%
Trust Total Compliance	**92%**

8. Appraisal compliance

8.1. Trust-wide appraisal compliance as at 31 July 2019 is 90%, against the Trust target of 90%.

8.2. Routine reminders and a series of letters to responsible managers from the Director of Workforce have been drafted in order to support a culture of sustainability of the level of appraisals.

Appraisal Completion by Division	
Core Clinical	94%
Corporate Services	87%
Medicines Unplanned Care	87%
Surgical Planned Care	90%
Women's and Children's	91%
Total Trust	**90%**



9. Staff flu immunisation campaign 2019/20

9.1. It has been estimated that 1 in 4 healthcare workers may become infected with flu during a mild season; the flu season typically starts in November.

9.2. The vaccination takes between 10-14 days to take effect; it is therefore important that healthcare workers receive their vaccine as soon as possible to ensure that they have sufficient protection; such is the potential impact on patients, colleagues and associated family/caring arrangements.

9.3. For 7 years, NHS Employers have led the 'Flu Fighter' campaign. From 2019/20, the frontline healthcare worker flu vaccination campaign will form part of the NHS England and Public Health England (PHE) winter campaign. An updated toolkit has been produced which includes social media, video and digital resources as well as some print items.

9.4. The Trust vaccination programme will run from 30 September 2019 to 29 February 2020 dependent on exact arrival date of vaccine supply into the Trust.

9.5. As in previous years, the campaign will be co-ordinated by the Staff Health and Wellbeing Department, supported and delivered by colleagues across the Trust.

9.6. Last year, the uptake was 76.92% (see appendix 1 for breakdown) and the Trust has achieved over 75% of flu vaccinations for the past three consecutive years. Approximately 80% of the Trust workforce is classed as 'frontline'. A target of 80% uptake is proposed and is deemed to be achievable given the success of preceding years.

Delivery of the campaign

9.7. One WTE corporately provided Band 5 nurse will visit wards/departments through the first 8 weeks, covering all shifts. Each clinical area will also have ward-based peer vaccinators and vaccine will be offered through all normal Staff Health and Wellbeing Department clinics.

9.8. This year, along with ward vaccinators, it is proposed that Doctors in Training will recruited to help vaccinate staff throughout their divisions.

9.9. As in previous years, the *#KungFuThatFlu* logo will be used again, on stickers, intranet and communications, with a weekly 'jabometer' to show uptake via the CEO's 'The Weekly' message.

9.10. A number of incentives will be offered in an effort to reach the desired target of 80% of frontline healthcare workers; these are known to be successful motivators in addition to internal leader boards which engender a sense of competition and camaraderie to efforts on the programme.

9.11. Areas with low compliance last year will be targeted to increase uptake.

10. Recommendations

10.1. Trust Board is asked to note the Workforce report and to approve the 2019/20 aspirational agency target of £9.7m (see section 5 of this report).

Appendix 1 – 2018/19 #KungFuThatFlu campaign – MKUH key statistics

Medicine	Vaccines Given	Headcount	% Uptake
A&E	80	118	**67.8**
AECU	12	15	**80.0**
Ward 1	25	39	**64.1**
Ward 2	23	39	**59.0**
Ward 3	19	33	**57.6**
Ward 7	25	48	**52.1**
Ward 8	27	34	**79.4**
Ward 14	15	29	**51.7**
Ward 15	21	36	**58.3**
Ward 16	23	38	**60.5**
Ward 17	22	30	**73.3**
Ward 18	24	38	**63.2**
Ward 19	23	28	**82.1**
Ward 22	26	36	**72.2**
BBV	19	28	**67.9**
Endoscopy	15	28	**53.6**
Surgical	**Vaccines Given**	**Headcount**	**% Uptake**
DOCC	33	38	**86.8**
Ward 20	25	37	**67.6**
Ward 21	28	38	**73.7**
Ward 23	30	50	**60.0**
Ward 24	18	24	**75.0**
Pre OP	5	16	**31.3**
Theatres	67	119	**56.3**
DSU	9	19	**47.4**
OPD	44	54	**81.5**
Eye Clinic	15	31	**48.4**

Vaccine administered by		
	Vaccines given	% Uptake
Ward Vaccinator	661	**25.8**
Walkabout	1540	**60.1**
Walkabout Night	30	**1.2**
OH Department	274	**10.7**
Elsewhere	59	**2.3**
Total	2564	

Trust headcount	Vaccines given	Headcounts	% Uptake
All Doctors	273	404	67.57%
Nurses and Midwives	750	1037	72.32%
Allied Health Profess	232	291	79.73%
Support to clinical	1235	1505	82.06%
All other staff	74	235	31.49%
Total	**2564**	**3472**	**76.92%**

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 5 September 2019
Report title:	Freedom to Speak Up Annual Report 2018/19	Agenda item: 5.1
Lead director Report author Sponsor(s)	Name: Danielle Petch Name: Adewale Kadiri Name: Joe Harrison	Title: Director of Workforce Title: Trust Secretary Title: Chief Executive
FoI status:		

Report summary	The role of the Freedom to Speak Up Guardian was created as a recommendation from Sir Robert Francis' report that was published in 2015 following his investigation into what went wrong at Mid-Staffordshire NHS Foundation Trust. All Trusts are required to have a Guardian in place to support members of staff who wish to raise concerns, but may feel unable to do so. Guardians are required to report to the Board at least annually on their activities. Philip Ball and Adewale Kadiri have been appointed as MKUH Guardians and this is their second annual report.			
Purpose *(tick one box only)*	Information ☐	Approval ☐	To note x	Decision ☐
Recommendation	That the Board notes the contents of this Annual Report and questions the Guardians and the executive lead about Freedom to Speak Up within MKUH			

Strategic objectives links	Objective 7 Become well governed and financially viable
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	This is an annual report
Next steps	
Appendices	

Freedom to Speak Up Guardian Annual Report 2018/19

Executive Summary

This is the second annual report to the Trust Board on Freedom to Speak Up in the Trust for the 12 months from April 2018 to March 2019. The Freedom to Speak Up Guardian is a relatively new role across the NHS and was created as one of the main recommendations of the Freedom to Speak Up Review carried out by Sir Robert Francis and published in 2015 subsequent to his main report about what went wrong at Mid-Staffordshire NHS Foundation Trust.

The role of Freedom to Speak Up Guardian was created at MKUH in April 2017. Its purpose is to provide independent and confidential support to staff who wish to raise concerns and promote a culture in which staff feel safe to raise those concerns. In the 12 months under consideration, 35 members of staff contacted the Guardians with their concerns. Most concerns were resolved locally: a small number progressed through more formal routes. In addition, other activities have been undertaken to raise awareness of Freedom to Speak Up and to encourage cultural change in the Trust.

This is an annual report. This report has not been presented to any committees or groups in the Trust.

Background to Freedom to Speak Up

Sir Robert Francis, in his Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013), described the experiences of nurses and doctors who raised whistleblowing concerns about the poor care of some patients at Stafford Hospital. As a result, he was asked to conduct a further review into whistleblowing in the NHS. Sir Robert subsequently published his report: 'Freedom to Speak Up – an independent review into creating an open and honest reporting culture in the NHS' in 2015. That document identified a number of measures that would help bring about a more open and transparent culture within the NHS including the need for cultural change from the top of organisations, improvements in the way whistleblowing cases are handled, measures to support good practice, particular measures for vulnerable groups, and extending legal protections. Sir Robert Francis identified 20 principles to address these themes, particularly recommending that all trusts should have a Freedom to Speak Up Guardian to 'act in a genuinely independent capacity' and support staff to raise concerns.

In 2016-17 it became a contractual requirement for all NHS provider trusts to have a Freedom to Speak Up Guardian. By the end of the financial year, all trusts in England had made appointments. Trusts were also expected to adopt a model NHS whistleblowing/raising concerns policy.

The National Guardian's Office (NGO) is an independent, non-statutory body with the remit to lead cultural change in the NHS so that speaking up becomes part of 'business as usual'. The office is not a regulator, but is sponsored by the CQC, and NHS England/Improvement.

The NGO supports the National Guardian for the NHS, Dr. Henrietta Hughes, in providing leadership, training and advice for Freedom to Speak Up Guardians based in all NHS Trusts. The Office also provides challenge, learning and support to the healthcare system as a whole by reviewing trusts' speaking up culture and the handling of concerns where they have not followed good practice. The NGO has a very small team, but its capacity to support Guardians has recently been enhanced by the appointment of regional liaison leads. Emma Duffield, the lead for the East of England recently visited MKUH to meet with the guardians here and provide updates on the latest national developments.

The Role of the Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian is not part of the management structure of the Trust and should be able to act independently in response to the concerns being raised. The Guardian reports directly to the Chief Executive, and this gives them access to the executive directors of the Trust. There are two key elements to the role:

- To give independent, safe and confidential advice and support to members of staff who wish to raise concerns that could have an impact on patient safety and experience.
- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions as consequence

At MKUH Nicky Burns-Muir, who was then the Deputy Chief Nurse, was appointed as the FTSU Guardian in April 2017 and undertook the role within her portfolio to establish the service and scope the ongoing requirements and infrastructure required to fulfil the role. Subsequently, Adewale Kadiri, the Trust Secretary, was appointed as the second Guardian to support the service and provide staff with an option of who to speak up to. Like Nicky, he took on the role in a voluntary capacity and as part of his primary role. Following her appointment as Chief Nurse in May 2019, it was agreed that it would no longer be appropriate for Nicky Burns-Muir to continue as Guardian. Philip Ball, the Lead for End of Life Care, was approached as to whether he would be willing to take up the role, and he agreed. He received his foundation training in July and has now formally taken on the role.

There is a dedicated email address freedomtospeakup@mkuh.nhs.uk for staff to contact the Guardians, but consideration is also being given to the creation of a telephone line as another way of contacting the Guardians, particularly for staff who do not normally use email.

More recently the NGO has encouraged the development of the FTSU Ambassador/Champion role – mainly as a way of signposting staff either to the Guardians, or to other support systems within the organisation, where their concerns may be more appropriately addressed. This has been seen as particularly helpful in larger and more geographically dispersed trusts but is seen as equally helpful here at MKUH where the 2 Guardians already have full-time roles. As such during 2018/19 expressions of interests were invited from any colleagues who wished to take up this opportunity. A number of people put themselves forward, and so far, two Ambassadors have been trained and appointed.

Freedom to Speak Up activities in the Trust

The FTSU information submitted for MKUH during 2018/19 was as follows:

Quarter	No of Cases	No. of Anonymous	Element of patient safety	Element of bullying and harassment	Detriment experienced by speaking up
Q1	4	3	2	2	0
Q2	10	10	4	6	0
Q3	12	0	10	2	0
Q4	9	4	7	2	1
Total	35	17 (49%)	23(66%)	14(40%)	1(3%)

Table 1. Submission data for 2018/19 to National Guardians Office

Based on this data and the figures from 2017/18, the following observations can be made:

- The overall number of colleagues raising concerns with the FTSU Guardians has remained broadly the same as in 2017/18 (28 staff came forward in the previous year, but no data was collected for quarter 1).
- There has been a significant fall in the number of staff speaking up who wished to remain anonymous. In 2017/18 90% of all those who spoke up did not wish to be named – this fell in 2018/19 to 49% and in the latter two quarters, only 4 of 13 disclosures were made anonymously. This is a positive development as it indicates that fewer colleagues now believe that they will face repercussions for speaking up.
- With regard to the one case in which those raising concerns indicated that they had suffered detriment, due to the small size of the team, the disclosure led to a deterioration in working relationships, as a result of which an HR process was instigated. This is now concluding, and once that process has ended, a thorough lessons-learnt exercise will be carried out to ensure that staff will continue to be protected while at the same time, the Trust's aim of creating a more transparent culture is not jeopardised.

- The percentage of staff raising concerns that included elements of patient safety rose in 2018/19, while those indicating bullying and harassment fell slightly.

The Board should also be aware of some broader trends arising from the Guardians' work over the year:

- As in 2017/18, the majority of staff who contacted the Guardians were nurses, both registered and healthcare assistants. Some concerns were also raised by clerical and administrative staff, but in the year, there were no concerns raised by medical staff.
- In many cases, the concerns raised related to issues that had been ongoing within the team or department for some time but had for a variety of reasons remained intractable. In some of those cases, the Guardian's intervention facilitated some resolution.
- The Guardians' intervention rarely resulted in formal investigations, but feedback received from those making disclosures indicates that the facility to raise their concerns and have them heard, often for the first time, had been beneficial in its own right.

<u>Changing the Culture</u>

As noted earlier in this paper, one of the key aims of Sir Robert Francis' recommendation was to help establish a culture of openness within the NHS. The MKUH Guardians, supported by the Director of Workforce as executive lead, are helping to achieve this in a number of ways including:

Raising awareness: All new staff are given information about Freedom to Speak Up as part of corporate induction and presentations have been given to student nurses and medical students. A further programme is required to raise awareness, including the development of a dedicated website, setting up a programme whereby guardians attend team meetings to deliver short presentations to promote FTSU. The Guardians may also be invited to attend meetings of the newly formed staff networks.

Staff Development: Unregistered care staff can often find it harder to raise concerns but spend most time in direct contact with patients. There is a need to develop opportunities to engage with professional groups and within leadership development training to empower staff to feel confident about speaking up, and also to prepare managers to receive feedback from their staff when they have concerns.

Influencing cultural change: There needs to be continued collaborative working with HR to develop a campaign to raise awareness about bullying and harassment and how to address and combat this behaviour.

National and Regional Developments

The National Guardian, Dr Henrietta Hughes, came into post in October 2016 and has been developing her role and the work of the National Guardian's Office. Training has been provided for new Guardians and guidance has been issued on recording information, case reviews and Freedom to Speak Up and CQC assessments of Trusts. Nationally there have been five annual conferences, the most recent of which took place in March 2019, but unfortunately due to work pressures, neither of the MKUH guardians were able to attend.

MKUH previously sat within both the East Midlands and Thames Valley Wessex regional guardians' networks and Guardians attended as many quarterly meetings as other commitments permitted to access support, share learning and learn about best practice. Following a recent national reorganisation to align FTSU with the NHSI/E regional structure, MKUH has now been placed in the East of England region, and the guardians will start to build relationships with colleagues across the area.

In July 2019, NHSE/I produced guidance entitled "Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts". This document restates the role of various senior leaders in an organisation, including the CEO, Chair and the FTSU executive and non-executive leads in ensuring that FTSU arrangements are fit for purpose. It also provides guidance on evaluating the capacity of the trust's Guardian resource, creating an effective communication strategy, the use of data, and how the board should seek assurance in this area. This guidance has been taken into account in preparing this report, but, going forward, the Guardians will work closely with the executive lead to ensure close compliance.

In August 2019, the NGO issued a document entitled "National guidelines on Freedom to speak Up training in the health sector in England", providing some suggestions on the content of training on FTSU for middle and senior managers. The Guardians will again work with the executive lead to see how these requirements can best be met.

Plans for 2019 – 20

- With the appointment of Philip Ball as a new Guardian, and the appointment of 2 new Ambassadors, it is intended that the whole MKUH approach to FTSU be re-launched at the "pop-up" event in the Tent on 19 September. The opportunity will also be taken to invite more people to put themselves forward as Ambassadors
- Development of a survey for staff who contact the Guardian to anonymously feedback on 'given their experience would they contact the guardian again?' the results of which will be collated quarterly. The survey will also contain questions about equality which will enable a picture of the type of staff contacting the

Guardian to be built up. As the quarterly collections of data by the NGO develop, they may enable some benchmarking with similar Trust to be undertaken.

- The addition of questions on the leaver's questionnaire about awareness of the FTSU Guardians and whether they had used the service.
- To participate in the development of the role of the Freedom to Speak Up Guardian and become active in the new East of England regional group.
- Evaluation of the effectiveness of the Freedom to Speak Up Guardian role in the Trust.

Recommendation

The Trust Board is asked to note the contents of the annual report by the Freedom to Speak Up Guardians.

Philip Ball, FTSU Guardian

Adewale Kadiri, FTSU Guardian

Exec Lead	Risk Ref	Objective	Committee	SRR link	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
							Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall				
IR	1-1	SO3	Quality & Clinical Risk	1917/2500	Strategic failure to manage demand for emergency care	Lack of demand management by the local health economy Inadequate primary care provision/ capacity Inadequate community care provision/ capacity Inadequate social care provision/ capacity	4x4=16	Working with partners to manage peak demand periods (e.g expediting discharge; using full community/ social care capacity)	Strategic planning at trust-wide and service level Strategic planning within local health economy (CCG, CNWL, GP Federation)	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	4x3=12	Executive strategy session; A&E Delivery Board monthly evidencing progress on DTOCs and system working	System-wide strategic plan	4x2 = 8
IR	1-2	SO3	Quality & Clinical Risk	1917/2500	Tactical failure to manage demand for emergency care	Annual emergency and elective capacity planning inadequate or inaccurate Daily flow/ site managmement plans inadequate or ineffectual Poor clinical/ operational relationships impacting on patient flow through the organisation Poor operational/ managerial relationships impacting on escalation Ineffective engagement with stakeholders to support patient flow day-to-day	4x4=16	Introduction of ED streaming Working with UCC to manage demand Implementation of national flow improvement programmes - Red2Green; 100% Challenge; EndPJParalysis; SAFER Strong clinical and operational leadership and ownership; good team working Clear escalation and well-known and understood flow management and escalation plans Positive relationships with stakeholders through daily working and medium-term planning	Daily operational oversight Medium-term planning at service-level Daily and short/ medium-term planning with local health economy partners to support flow and right care/ right place	Regular strategic planning withing the system - include Emergency Care Delivery Board Regular reporting to Management Board; Committees and Trust Board on strategic planning	System-wide Emergency Care Delivery Board Regular NHSI oversight (PRMs) External scruitny through Transformation Board, Health and Wellbeing Board and Health Overview and Scrutiny Committee Part of ICS (STP) priority programme on acute care	Good	4x3=12	Daily management	Length of Stay Programme Board - 11 key work streams to support flow, including multi-agency input	4x2 = 8
IR	1-3	SO1	Quality & Clinical Risk	1917/2500	Ability to maintain patient safety during periods of overwhelming demand	Significantly higher than usual numbers of patients through the ED Significantly higher acuity of patients through the ED Major incident/ pandemic	5x4=20	Clinically and operationally agreed escalation plan Adherence to national OPEL escalation management system Clinically risk assessed escalation areas available	Daily operational management command structure in place to manage emergency and elective activity safely Clinical site team 24/7 SMOC and EOC 24/7 Daily patient safety huddle	Daily reporting to clinical, oeprational and executive management Daily sit-rep reporting to regulatory and commissioning bodies Twice-monthly oversight at Management Board (formal reporting)	Daily sit-rep reporting and review by external bodies (CCG, NHSI, NHSE)	Good	4x3=12	Daily management	Continue to clinically review escalation plans in line with demand to ensure patient safety is no compromised	4x2 = 8
IR	1-4	SO1	Quality & Clinical Risk	1472	Failure to appropriately embed learning and preventative measures following Serious Incidents, complaints, claims and inquests	1. Failure to appropriately report, invesitgate and learn from incidents and complaints 2. Lack of system to share learning effectively from incidents - both in departments/ CSUs and across the Trust 3. Lack of evidence of learning from incidents	5x3=15	All SIs and action plans processed through the Serious Incident Review Group Actions including learning distribution tracked through SIRG Core component of all Clinical Improvement Group Meetings Lessons communicated via Trust-wide channels Debriefing embedded in specialties and corporately Training and skills programme annually Cultural work (inc Greatix and FTSU Guardians	Incident reports and action plans Performance information on incident numbers Emerging or existing trends analysed and reported Repeat incidents analysed and reported - particularly for failure to learn	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	CCG satisfaction with RCA reporting Stakeholder involvement with RCA/SI investigation Internal Audit review of SI process	Satisfactory	4x3=12	August/ September 2019 Lack of evidence around learning picked up in the CQC inspection (May 2019) Launch of online Learning Hub - linked to Greatix and Appreciative Inquriy Greatix and T-REX (reporting excellent) event in September to focus on learning QI programme to support shared practice and learning	Action plan to be developed to support August/ September event programme CQC action plan includes thematic section on learning	4x1 = 4

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IR	1-5	SO1	Quality & Clinical Risk	2495/2497	Failure to recognise and respond to the deteriorating patient	Non compliance with the NEWS protocols; failure to appropriately escalate NEWS scores or failure to clinically assess patients outside protocols (i.e. 'hands on, eyes on' patients who are ill but not triggering on NEWS)	5x3=15	National NEWS protocol in place Level 1 pathway in place Successful implementation of NEWS 2 Sepsis screening and training/ awareness programme	Performance is reported to the Clinical Quality Board and is regularly audited Serious Incident Review Group process where issues around deteriorating patient identified eCare implementation supports early earning systems Standardised mortality review process to identify issues and learning	Serious Incident Review Group Oversight at Clinical Quality Board Oversight at Quality and Clinical Risk Committee	Coronial review of deaths	Satisfactory	4x3=12	Good evidence being demonstrated through eCare reporting metrics. Monthly oversight at executive level continues	Individual action plans where incidents reported to prevent repeat incidents ED review meeting March 2019	4x2 =8
IR/ NB-M/ KJ	1-6	SO10	Quality & Clinical Risk		Failure to manage clinical risk during significant digital change programmes	1. Inadequate assessment of clinical risk/ impact on clinical processes and safety/ experience of digital change prgrammes 2. Inadequate resourcing of digital change programmes (including operational support) 3. Inadequate training for clinicians and support staff on new digital systems prior to and post roll out	4x4=16	1. Robust governance structures in place with programme management at all levels 2. Thorough planning and risk assessments during scoping, testing, launch and roll out 3. Resourcing reviewed regularly at programme boards 4. Training needs established in scoping and testing phases 5. Regular reviews of progress post go-live for all digital change programmes	1. Executive chaired Health Informatics Programme Board 2. Robust governance structures, programme management structures and reporting	1. Progress reporting and oversight at Management Board 2. Reporting on major change programmes at Trust Board	1. Peer review and benchmarking throguh Global Digital Exemplar programme 2. Benchmarking through suppliers and other adopting sites 3. Access to support via NHS Digital/ NHS X	Satisfactory	4x3=12	HIPB terms of reference revised to incorporate all digital change programmes to integrate governance and reporting	Digital programme to Trust Board in November 2019	4x2 =8

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NB-M	2-1	SO2	Quality & Clinical Risk	2598	Failure to achieve improvements in the patient survey	Lack of appropriate intervention to improve patient experience (measured through the national surveys)	4x4=16	Prevent Controls Coporate Patient Experince Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to: • Patent Experince Strategy • Learning Disabilities Strategy • Dementia Strategy • Nutrition steering group • Catering steering group • Domestic planning group • Discharge steering group • Induction training Detect Controls Quarterly Patient Experience Board , monthly meetings and supporting substructure of steering groups .	Perfect Ward patient experince audits on all wards monthly. Patient Experience action plans from each patient survey reviwed at divisional CIG. Locally designed audits to focus on areas of improvement to monitor progress. Patient Experience Volunteers collecting weekly data on agreed Patient Experience measures and outcomes. 15 Step Programme all areas.	FFT collation of monthly data submitted to unify and published locally and nationally . Quarterly Patient Experience Report to management Board. Patient Experience data presented on Trust dashboard reviewed at Trust Board. Quarterly Patient Experience Board to gain oversight and monitoring of cross organisational improvement measures.	Annual Patient Survey Results for : Adults inpatients Emergency Department Children and Young People Maternity External visits inspections and reviews from: MK CCG Healthwatch CQC Experts by experience group	Satisfactory	4x3=12		Action plans for ; Paient Experince strategy Learning disabilities strategy Dementia strategy Linked with CQC action plan.	4x2=8

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NB-M	2-2		Quality & Clinical Risk		Failure to embed learning from poor patient experience and complaints	Learning not captured and shared in a meaningful and impactful way among individuals and team (and across the organisation) Failure to embed an appropriate system for sharing learning consistently, in a way that can be measured/ audited and evidenced	4x4=16	Prevent Controls Corporate PALS/Complaints Team function, resouces and governance in place at the Trust, division and department levels, including but not limited to : • Complaints policy and process • PALS policy and process • Ombusman policy and process • Complaints handling traininf for managers • Clinical oversight complaints/PALS process Detect Controls Quarterly Patient Experience Board, monthly meetings and integration with Patient Experience sub structure of steering groups.	Rag report to Executive Directors including delays and escalation requirements weekly. PALS walkround monthly audits. Perfect Ward patient experience audits on all ward monthly. Complaints action report each divsion monthly providing complaints performance actions and learning for review at CIG. Ward/department patient experince meetings traingulating all patient experince feedback and complaints data .	Monthly submission of complaints data against complaints/PALS KPIs to inform Trust scorecard presented at Trust Board Quarterly Complaints/PALS report to management board. Quartely Patient Experience Board to gain oversight and monitoring of themes / areas of complaints/ analysis and thematic review. Patient story at each public board based on poor experience and complaints.	External Audit of Complaints process. Benchmarching against peer organisations. Review of complaints thematic review with MK CCG . External inspection CQC.	Satisfactory	4x3=12		Action Plan: Complaints process audit. Dvisional complaints moitoring for completion and evidence of learning.	4x2=8

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KB/IR	3-1	SO3	Quality & Clinical Risk		Failure to evidence compliance with the annual clinical audit programme	1. Lack of understanding/ awareness of audit requirements by clinical audit leads 2. Resources not adequate to support data collection/ interpretation/ input 3. Audit programme poorly communicated 4. Lack of engagement in audit programme 5. Compliance expectations not understood/ overly complex	4x4=16	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative support - allocated by division 3. Recruited additional clinical governance post to medicine to support audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement	1. Tracking of audit programmes at divisional level 2. CIG meetings	1. Tracking of programme at Clinical Audit and Effectiveness Board; Management Board; Quality and Clinical Risk Board; Audit Committee 2. Oversight at Board of Directors as part of the Trust's strategic objectives	1. Internal audit - part of 2020 programme 2. Peer review	Satisfactory	4x3=12	August/ September 2019 1. Updated Audit Policy 2. Revised audit programme structure - link with QI programme 3. Simplified audit database and compliance process	Action plan - progress reporting linked to objectives	4x2=8
KB/IR	3-2	SO3	Quality & Clinical Risk		Failure to embed learning and evidence action plans following clinical audit	1. Learning from audits not captured effectively 2. Learning from audit not shared effectively 3. No central record of learning from audit or ability to compare audit/ re-audit progress	4x4=16	1. Designated audit leads in CSUs/ divisions 2. Clinical governance and administrative support - allocated by division 3. Recruited additional clinical governance post to medicine to support audit function (highest volume of audits) 3. Audit programme being simplified, with increased collaboration and work through the QI programme 4. Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement	1. Tracking of audit programmes at divisional level 2. CIG meetings	1. Tracking of programme at Clinical Audit and Effectiveness Board; Management Board; Quality and Clinical Risk Board; Audit Committee 2. Oversight at Board of Directors as part of the Trust's strategic objectives	1. Internal audit - part of 2020 programme 2. Peer review 3. Independent re-audit process	Satisfactory	4x3=12	August/ September 2019 1. Updated Audit Policy 2. Revised audit programme structure - link with QI programme 3. Simplified audit database and compliance process	Action plan - progress reporting linked to objectives	4x2=8

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KB/IR	3-3	SO3	Quality & Clinical Risk	767	Lack of assessment against and compliance with NICE guidance	The Trust has a significant backlog of NICE guidelines	3x4=12	Monthly assessments of compliance against published NICE baseline assessments Process in place to manage baseline assessments with relevant clinical lead - supported by clinical governance leads Independent review by compliance and audit lead Requires clinical engagement and ownership	Oversight and scrutiny at Clinical Effectiveness Board; Risk and Compliance Board and Clinical Quality Board Internal compliance monitoring and reporting monthly Reporting to CIGs and divisional management meetings	Oversight at the Quality and Clinical Risk Committee	1. Peer review 2. Consider for Internal audit programme in 2020	Low - Rated Low as compliance not improved in first quarter (for review following August/ September action plans)	3x4=12	August/ September 2019 1. Review of NICE baseline assessment and documentation process 2. KPIs for NICE baseline assessment completion and compliance (time to assessment, time to compliance or escalation) 3. Escalation process for breaches to Divisional Management and then Executive Management	Action plan developed linked to August/ September update - reporting to October 2019 Quality and Clinical Risk Committee	(4x2) = 8
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IR	4-1	SO4	Executive Management	1917/2500	Failure to meet the 4 hour emergency access standard	The Trust is unable to meet the target to see 95% of patients attending A&E within 4 hours	4x4=16	Operational plans in place to cope with prolonged surges in demand Cancelling of non urgent elective operations New elective surgical ward open to reduce liklihood of above control Opening of escalation beds Working with partners for social, community and primary care	Divisional and Trust performance reports Rates of discharge; DTOC	A&E Delivery Board	Ongoing NHSI review of key indicators Internal audit work on data quality Quality Report testing of key indicators by external auditors	Satisfactory		Current performance remains better than 2017/18 although variable day-to-day. Work continues with MK system through A&E delivery board.	Length of Stay Programme Board - 11 key work streams to support flow, including multi-agency input Regular MADE events	4x2 = 8
IR	4-2	SO4	Executive Management	2679/2589	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	The Trust is unable to meet the 18 week RTT and 62 day cancewr targets, and unable to reduce its non-RTT backlog as required	4x4=16	Regular PTL meetings Work on improving administrative pathways Work with tertiary providers on breach allocations RTT and non-RTT action plans	Divisional and Trust performance reports Management Board scrutiny and oversight of RTT and non-RTT action plans	Finance and Investment Committee scrutiny of financial and operational performance Quality and Clinical Risk Committee oversight	NHSI regional information on performance against key access targets	Satisfactory		Recovery plans established. Additional resource in surgery and T&O. Alternative models to increase capacity and reduce waiting lists approved. Long waiters actively managed. Increased oversight by executive. Weekly reporting to executive directors.	Monitored through weekly PTL RTT improving on a continued trajectory	4x2 = 8
JB	4-3	SO4	Audit	2705/2572	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	Data quality governance and processes are not robust	4x3=12	Robust governance around data quality processes including executive ownership Audit work by data quality team	Oversight of progress against action plans by Data Quality Compliance Board	Standing agenda item at the Audit Committee	Outcome of Internal audit assessment of data quality Outcome of External Audit Quality Report testing Outcome of NHSI review	Satisfactory		Testing commenced in specialties where new outcome forms have been in active use for three months or more (September 2018).	Regular programme of audit and testing	4x2= 8
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JB	5-1	SO5	Audit		Failure to adequately safeguard against major IT system failure (deliberate attack)	Weaknesses in cyber security leave the trust vulnerable to cyber attack	5x2=10	Investment in better quality systems GDE investment NHS Digital audits and penetration tests	Results of penetration and phishing tests	Audit Committee review of cyber security	Performance against NHS Digital standards	Good		Positive relationship with NHS regulators continues to develop, now evidence of being in top decile of NHS performers nationally.		4x2 = 8

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JB	5-2	SO5	Finance & Investment		Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	Lack of suitable and timely investment leaves the Trust vulnerable to cyber attack	4x2=8	2 dedicated cyber security posts funded through GDE All Trust PCs less than 4 years old Robust public wifi network EPR investment	Robust capital prioritisation process overseen by Managment Board	Oversight of IT investment strategy and decision making by the Finance and Investment Committee	External oversight of uses of the GDE funding	Good		Positive relationship with NHS regulators continues to develop, now evidence of being in top decile of NHS performers nationally.		4x2 = 8
CH	5-4	SO5	Executive Management	2177/1185	Failure to maximise the benefits of EPR	That the Trust does not derive all of the benefits in terms of efficiency and productivity from the EPR system as had been anticipated in the business cases	4x3=12	eCare operational delivery board being put into place in order to cover the spectrum of optimisation opportunities both financial and non-financial as a result of the implementation (and upcoming upgrades and changes). An initial schedule of opportunities that forecasts a lvel of savings in line with those in the original business case is being monitored against although there is likely to be some slippage against this when taking into account time for the new system to bed-in across the organisation.	Delivery of financial savings against those specified in the original business case. Delivery of non-financial savings, particualrly releasing time-to-case	Reporting and scrutiny at the Finance and Investment Committee, HIPB and Management Board	External peer review with West Suffolk NHS FT and other Cerner sites	Satisfactory		Monthly oversight at executive level continues		3x2 = 6

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MK	7-2	SO7	Finance & Investment		There is a risk that the constraints on the NHS capital expenditure limit (CDEL) lead to delays in the Trust receiving its approved capital funding or other restrictions being placed on the Trust's capital programme	The national NHS Capital Financing regime is under significant pressure, which is restricting the Trusts ability to spend on capital above its Capital Expenditure Limit	5x4=20	1. Annual plan re-submitted to include only approved capital loans from DHSC. Funding sources identified for other schemes. 2. Capital prioritisation process in place (through the Trust's Capital Control Group (CCG) and Clinical Board Investment Group (CBIG) to ensure the Trust prioritises its capital schemes within scarce resources effectively	Capital expenditure is reviewed at the monthly Capital Control Group and the Management Board	Updates reported to the Finance and Investment Committee and Trust Board	The Trust reports its capital expenditure to NHSI in its monthly financial reporting and has discussions on capital spend as part of its NHSI Progress Review		4x4=16	Following a request from NHSI, the Trust has reviewed its capital plan submission and following this, has reduced its capital expenditure plan in 2019/20. In addition, the Trust has removed any requirement for DHSC loan financing where these have not been pre-approved.	Continual discussion of the Trust's capital plan at the monthly PRM meetings with NHSI/E and F&I committee meetings	4x3=12

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MK	7-3	SO7	Finance & Investment		There is a risk that the Trust does not receive timely confirmation that its revenue loans due for repayment in 2019/20 have been refinanced leading to a potential breach of the DHSC loan agreements and risk to going concern	The DHSC process for reviewing revenue loan repayments for loans that are at the end of their term is not fully determined and thus approvals take a significant amount of time	5x5=25	1. NHSI and DHSC are aware that the Trust is unable to make its loan repayments; 2. DHSC has confirmed that refinancing decisions will be made in 2019/20 where required	Discussion with NHSI regional finance team Monitoring of cash flow forecast within finance department (and reported to Management Board, Finance and Investment Committee and Trust Board)	Updates reported to the Finance and Investment Committee and Trust Board	Submission of cash flow forecasts to NHSI to support requests for additional revenue funding.		5x3=15	A letter has been received from DHSC which notes that: 'In advance of wider reforms, the Department recently agreed extensions to loans due during the 2018-19 financial year to November 2019. The Department will continue to take refinancing decisions on loans due in the coming year.'	Continual discussion of the Trust's revenue loan repayments at the monthly PRM meetings with NHSI/E and regular updates provided to the F&I committee	5x2=10
MK	7-4	SO7	Finance & Investment		There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan and the potential loss of the £5.1m of Provider Sustainability Funding in the event the Trust's control total is not met.	Transformation schemes are taking longer to implement and identify due to other competing priorities.	5x5=25	1. Tracker in place to identify and track savings and ensure they are delivering against plan 2. Savings measured against Trust finance ledger to ensure they are robust and consistent with overall financial reporting 3. All savings RAG rated to ensure objectivity 4. Oversight of the transformation programme through the Transformation Programme Board and Management Board.	1. Divisional CIP review meetings in place attended by the DoF, divisional managers and finance business partners. 2. Cross-cutting transformation schemes in place with dedicated programme resource. 3. Savings plan for 19/20 financial year not yet fully identified.	Monthly CEO chaired Transformation Board oversight, providing leadership and scrutiny of programme delivery	Review of transformation s schemes by NHSI through the monthly finance reporting and NHSI Progress Review Meetings.		4x4=16	The Trust is forecasting to achieve its control total for 2019/20, however not all schemes have been fully identified to support the £8.4m savings required for 2019/20. Therefore the risk scoring has been assessment and has been increased to 16.	On-going discussions of the progress of Divisional CIP's at the monthly performance review meetings attended by the DoF	3x3=9
MK	7-5	SO7	Finance & Investment		There is a risk that the Trust's guaranteed income contract does not deliver the benefits expected and/or leads to an opportunity cost to the Trust in respect of unfunded activity.	Increases in unfunded activity and costs.	5x4=20	1. Clearly defined monitoring of the monthly activity performance with lead commissioner 2. Escalation of issues to senior managers within the Trust. 3. Newly established joint executive contract mobilisation group to assess activity and performance and monitor the delivery of joint initiatives.	1. Clearly defined monitoring of the monthly activity performance with lead commissioner 2. Escalation of issues to senior managers within the Trust. 3. Newly established joint executive contract mobilisation group to assess activity and performance and monitor the delivery of joint initiatives.	Updates reported to the F&I Committee and Trust Board on a monthly basis			4x4=16	The Trust has some mitigations against cost increases above these outlined in its plan submission. These will be closely monitors on a monthly basis	The F&I committee to review on a monthly basis the Trusts income and costs .	3x3=9
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DP	8-1	SO8	Workforce	2499/2589	Inability to retain staff emmployed in critical posts	Poor working culture within certain isolated teams Perceived more attractive benefits elsewhere Proximity to tertiary centres with perceived better career development opportunities	4x4=16	Variety of organisational change/staff engagement activities, e.g. Event in the Tent Schwartz Rounds and coaching collaboratives Recruitment and retention premia We Care programme Onboarding and exit strategies/reporting Staff survey Learning and development programmes Health and wellbeing initiatives, including P2P and Care First Staff friends and family results/action plans Links to the University of Buckingham Staff recognition - staff awards, long service awards, GEM Leadership development and talent management Succession planning Enhancement and increased visibility of benefits package Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment Enhanced Benefits Package	Monthly reports to Workforce Board and Management Board Workforce transformation reports Line managers' work on staff retention Supported departmental initiatives in response to staff survey, e.g. We Care programme	Reports to Workforce and Development Assurance Committees and the Finance and Investment Committee	NHSI Model Hospital benchmarking NHS Improvement staff retention exercise	Satisfactory	4x3=12	Participation of NHSI Retention Programme - driving down MKUH retention rates	2018 Staff Survey Action Plans 2019 Staff Survey plans - including Staff Appreciation Week events Expansion of Benefits Package literature and marketing materials Succession planning/talent management activities	4x2 = 8
DP	8-2	SO8	Workforce	2499/2589	Inability to recruit to vacancies in short term (0-18 months)	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level for dermatology and acute medicine, and at middle grade level for urology and trauma and orthopaedics Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips supply)	4x3=12	Active monitoring of workforce key performance indicators Targeted overseas recruitment activity Apprenticeships and work experience opportunities Exploration and use of new roles to help bridge particular gaps Use of recruitment and retention premia as necessary Use of the Trac recruitment tool to reduce time to hire and candidate experience Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Rollout of a dedicated workforce website Review of benefits offering and assessment against peers Creation of recruitment "advertising" films Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and	Vacancy control panel Divisional deep dive sessions Monthly reports to Management Board Workforce Board oversight Use of workforce planning templates Outcomes from the recruitment and retention task and finish group Workforce transformation reports HR systems and compliance report	Quarterly reports to the Workforce and Development Assurance Committee Staff survey results	NHSI Model Hospital benchmarking Staff survey results	Satisfactory	4x3=12	The Trust is assured that recruitment is adequate and that there is a ready pool of suitable candidates for most posts. However, there are some key hard to fill roles nationally, such as gastroenterology, urology and trauma and orthopaedics, and targeted recruitment is underway. All recruitment avenues are being exhausted.	Continuation of recruitment activity Review and refresh of Trust's workforce website. Further reduction in time to hire Enhanced on-boarding programme Creation of Benefits Package literature and marketing materials Creation of bespoke role based recruitment strategy Succession planning/talent management activities	4x1 = 4

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							Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall				
DP	8-3	SO8	Workforce	2499/2589	Inability to recruit to vacancies in medium to long term (19+ months)	National shortages of appropriately qualified staff in some clinical roles, particularly at consultant level Brexit may reduce overseas supply Competition from surrounding hospitals Buoyant locum market National drive to increase nursing establishments leaving market shortfall (demand outstrips suply) Large percentage of workforce predicted to retire over the next decade Large growth prediction for MK - outstripping supply Buoyant private sector market creating competition for entry level roles New roles upskilling existing senior qualified staffcreating a likely gap in key roles in future (e.g. band 6 nurses) Reducing potential internaltional supply New longer training models	4x4=16	Monitoring of uptake of placements & training programmes Targeted overseas recruitment activity Apprenticeships and work experience opportunities Expansion and embedding of new roles across all areas Rolling programme to recruit pre-qualification students Use of enhanced adverts, social media and recruitment days Review of benefits offering and assessment against peers Development of MKUH training programmes Workforce Planning Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/environment International workplace plan Assisted EU staff to register for settled status and discussed plans to stay/leave with each to provide assurance that	Vacancy control panel Divisional deep dive sessions Monthly reports to Management Board Workforce Board oversight Use of workforce planning templates Outcomes from the recruitment and retention task and finish group Workforce transformation reports	Quarterly reports to the Workforce and Development Assurance Committee Staff survey results	NHSI Model Hospital benchmarking Staff survey results	Satisfactory	4x4=16	23/4/19 - none - new entry	Develop bespoke MKUH training programmes, including placements Develop MKUH Clinical Education Strategy Develop detailed Workforce Planning function and embed as BAU Continue to keep in cotact with EU-nationals as Brexit progresses Develop new roles and strategy for embedding - ensuring linked to Workforce Plan and Education Strategy Make full use of Apprentice Levy to fund upskilling Implement Benefits Package and Flexible Working options to improve retention Succession planning/talent management activities	4x2=8
	9-1	SO9	Finance & Investment	2570	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	The current size of the Neonatal Unit does not meet the demands of the service. This risks high numbers of transfers of unwell babies and potential delayed repatriation of babies back to the hospital. There is a risk that if the Trust continues to have insufficient space in its NNU, the unit's current Level 2 status could be removed on the basis that the Trust is unable to fulfill its Network responsibilities and deliver care in line with national requirements.	4x3=12	Reconfiguration of cots to create more space Additional cots to increase capacity Parents asked to leave NNU during interventional procedures, ward rounds, etc to increase available space	Daily clinical management and operational oversight NNU feasibility study completed.	Oversight at Trust Baord through capital programme and via risk reporting	Neonatal Network engaged in work programme	Satisfactory		Initial draft cost plan received. Decant solutions and equipment to be assessed.	Outline business case for NNU re-build being developed by the Estates Department and submitted to the STP for consideration	4x2 = 8
Exec Lead	Risk Ref	Objective	Committee		Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score

Exec Lead	Risk Ref	Objective	Committee	SRR link	Risk Description	Cause	Inherent risk rating	Existing mitigation/controls	Assurance (First Line - Operational)	Assurance (Second Line - Management)	Assurance (Third Line - Independent)	Assurance Rating	Residual risk rating	Progress since last report	Action Plans	Target risk score
							Consequence v Likelihood		Level 1 Operational (management)	Level 2 Oversight functions (Committees)	L3 Independent	Overall				
KJ	10-1	SO9	Charitable Funds		Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	Lack of suitable and timely engagement with key players within the city and wider area during the private phase of the appeal, and an inability to enthuse and gain the support of potential donors more broadly, means that the Charity is unable to achieve the required level of charitable contribution to the project	4x2=8	Fundraising strategy and plan in place Financial forecasts under very regular scrutiny Experienced consultancy engaged to support existing senior and experienced fundraising staff Tactical plan for private and public appeal phase developed and implemented	Regular reporting to Committee Operational oversight	Oversight at Charitable Funds Committee	Appeal Leadership Committee	Satisfactory		Income forecasts in place and reiewed weekly.		3x2 = 6
JH	10-2	SO10	Board of Directors		Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	Lack of effective collaboration among all the key local partners means that the goal of a comprehensive and integrated place based health and social care solution within MK is not realised	4x3=12	Chief Executive and Executive team engagement both at ICS and MK Place levels. MK Place leaders chairing 3 of the 5 ICS priority workstreams	Direct MKUH senior involvement in decision making. Regular CEO progress updates to Management Board	Standing agenda item at the Trust Board	NHSE/I oversight	Satisfactory				4x2 = 8
JH	10-3	SO10	Board of Directors	2731	Insufficient preparedness for disruption to workforce or supplies (including medications) following withdrawal from the European Union	Inability to recruit or retain staff; inability to prescribe or supply pharmaceuticals; inability to keep hospital stock levels (clinical and non-clinical) at required levels	5x2=10	UK Government putting contingency plans in place Planning through Trust EPRR forums Trust working with NHSI/E to ensure any national directives are complied with	Regular communication with NHSI/E Assurance through EPRR local/ regional and national forums	Oversight at Trust Board	National Government policy	Satisfactory		No progress to note	Action plans as part of EPRR business continuity. Also overseen by Director of Workforce (with rsponsibility for EU exit preparations)	5x1 = 5

Meeting title	**Trust Board**	**Date: 5 September 2019**
Report title:	**Infection Prevention and Control Annual Report (draft)**	**Agenda item: 5.3**
Lead director **Report author** **Sponsor(s)**	**Name: Nicola Burns-Muir** **Name: Angela Legate** **Name:**	**Title: Chief Nurse** **Title: Assistant Director, Infection Prevention**
FoI status:		

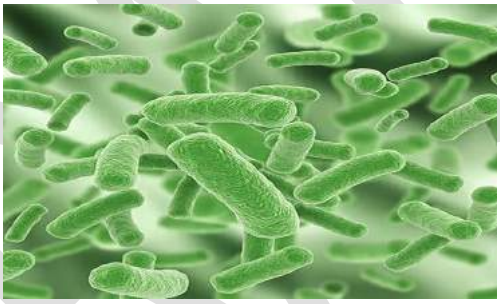
Report summary	**Describes IPC activity across the reporting year April 2018 – March 2019**						
Purpose *(tick one box only)*	**Information**		**Approval**	x	**To note**		**Decision**	
Recommendation	For information and approval						

Strategic objectives links	**Objective 1: Patient safety** **Objective 3: Clinical effectiveness**
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	
Legal implications including equality and diversity assessment	

Report history	The Trust is required to publish an annual IPC report as a demonstration of good governance and public accountability in this area. The report has been presented at Management Board.
Next steps	
Appendices	

The Infection Prevention and Control Annual Report for the period April 2018 – March 2019.

Author: Angela Legate – Assistant Director, Infection Prevention and Control



Graphics by Martin Parker – Infection Prevention and Control Data Analyst

Contents

Introduction and Welcome

Welcome to this report on the developments and performance related to Infection Prevention and Control (IPC) during 2018/19 at the Milton Keynes University Hospital NHS Foundation Trust.

The publication of the IPC Annual Report is a requirement to demonstrate good governance and public accountability. It also offers the opportunity to acknowledge the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholder experience through their diligence in helping to reduce the risk of infections.

The Trust Board recognises its collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks.

The responsibility for Infection Prevention and Control (IPC) is designated to the Director of Infection Prevention and Control (DIPC), supported by the IPC Team.

The Annual Report, together with the Annual Plan are the means by which the Board assures itself that prevention and control of infection risk is managed effectively and that the Trust remains registered with the CQC without conditions.

The Trust continues to work collaboratively with several external agencies as part of its IPC and governance arrangements, including:

- Milton Keynes Clinical Commissioning Group (CCG)
- Central and North West London (Diggory Division) IPCT
- Public Health England (PHE) Local Centre and East of England
- GP surgeries, District Nurse Teams, Mental Health and Learning Disabilities providers, Milton Keynes Council.
- Our staff, patients and local communities.

Key achievements over the reported year.

The Trust has maintained and achieved in the following areas:

- Continuing compliance with Care Quality Commission regulations relating to Infection Prevention and Control.
- Improving awareness of sepsis signs, symptoms and management
- Steady improvement in audit results across the Trust which reflects both improvements in Infection Prevention and Control practices, but also the environment, due to close working with the estates and facilities teams
- Progressing compliance with the Antimicrobial Prescribing Guidelines within inpatient wards.
- Overall incidence of Healthcare Associated Infection remains low with fifteen (15) cases of Clostridium difficile and zero Meticillin Resistant Staphylococcus Aureus bacteraemia attributable to the Trust.
- Achieving the national target for staff influenza immunisations
- Meeting the national programme to reduce gram negative blood stream infection (GNBSI)
- Appointment of a new Consultant Microbiologist, data analyst and trainee infection control nurse.

Organisational accountability for Infection Prevention and Control Roles and responsibilities IPC is the responsibility of everyone in the organisation. Key roles and arrangements are detailed below:

Chief Executive Officer (CEO) - has overall responsibility for ensuring that there are effective management and monitoring arrangements provided for IPC to meet all statutory requirements.

Director of Infection Prevention and Control (DIPC)- this role is the responsibility of the Executive Director of Patient Safety, Chief Nurse position and involves ensuring that systems and processes are in place in response to external and internal requirements to minimise risk to staff, service users and visitors and guarantee compliance with the Code. The DIPC or a nominated deputy is the Chair of the Infection Prevention and Control Committee.

Infection Prevention and Control Committee – this remains a mandatory requirement and acts as a key forum in the provision of assurance regarding structures and arrangements in place to meet all IPC statutory requirements.

Infection Prevention and Control Team (IPCT) - role and function is to provide specialist knowledge, advice and education for staff, service users and visitors.

All work undertaken by the team assists the Trust with on-going compliance to the Code.

The Infection Prevention and Control team has links with the wider infection prevention and control networks and through the Hospital Infection Society which enables team members to develop their knowledge and awareness whilst promoting interaction across the region.

Training and development (staff, patients and visitors)

IPC training is an integral part of Trust induction and mandatory clinical essential training. The content covers all IPC principles as directed by the national standards. Education is also delivered in response to root cause analysis investigations and audit outcome. The IPC team support frontline staff in providing a proactive service which includes taking training to wards, departments and public areas as needed.

Training and development (IPCT)

The team's own education seeks to ensure that we continue to deploy training and competencies in the application of behavioural theories across a wide range of interventions designed to prevent or contain infection in a diverse population, particularly as patient presentation is often uncertain, and many clinical processes need to be individualised to each patient.

Our quality improvement approaches are focused on refining processes, systems and clinical practice with emphasis on the reductive measures in place to drive down the incidence of HCAI for our hospital and our local communities.

The Trust wide action plan for sepsis continues to be reviewed and monitored.

- A sepsis e-learning module is available
- Face to face sessions continue to be delivered extensively across the Trust at induction, mandatory and as ad-hoc training.
- A Trust wide policy has been developed to reflect the requirements of the NICE guidance, this includes algorithms for patient care in all settings.
- The Trust wide sepsis awareness campaign was systematically delivered across 2018
- ECare pathways assessment is mandatory for all patients.

Antimicrobial Resistance

We are signed up to the 5-year plan (Gove & Hancock 2019) that offers a comprehensive view of how we might tackle antimicrobial resistance (AMR).

It is worth noting that we are the first country to set an ambition to reduce the actual number of resistant infections. Our collective aim to develop real time patient level data is so that clinicians can see infection, treatment and resistance histories to optimise life-saving treatments for serious infections, including sepsis, and to help develop new interventions for AMR.

Our hospital has few single rooms with ante room/en-suite facilities…not much we can do in the short term!

However, our strength comes from having the patient safety huddle to communicate, an IPCT that visits the affected areas to ensure all containment is being met, a patient pathway that has the facility for “high risk” issues to remain at the forefront of care delivery, in-house domestic/support teams well versed in the cleaning regimes for these patients and our own core staff that review and reinforce the message at each shift change.

Healthcare worker education and professional development now has a stronger emphasis on antimicrobial stewardship but is wholly dependent on a co-ordinated approach staying embedded if we are to maintain a responsive health care system.

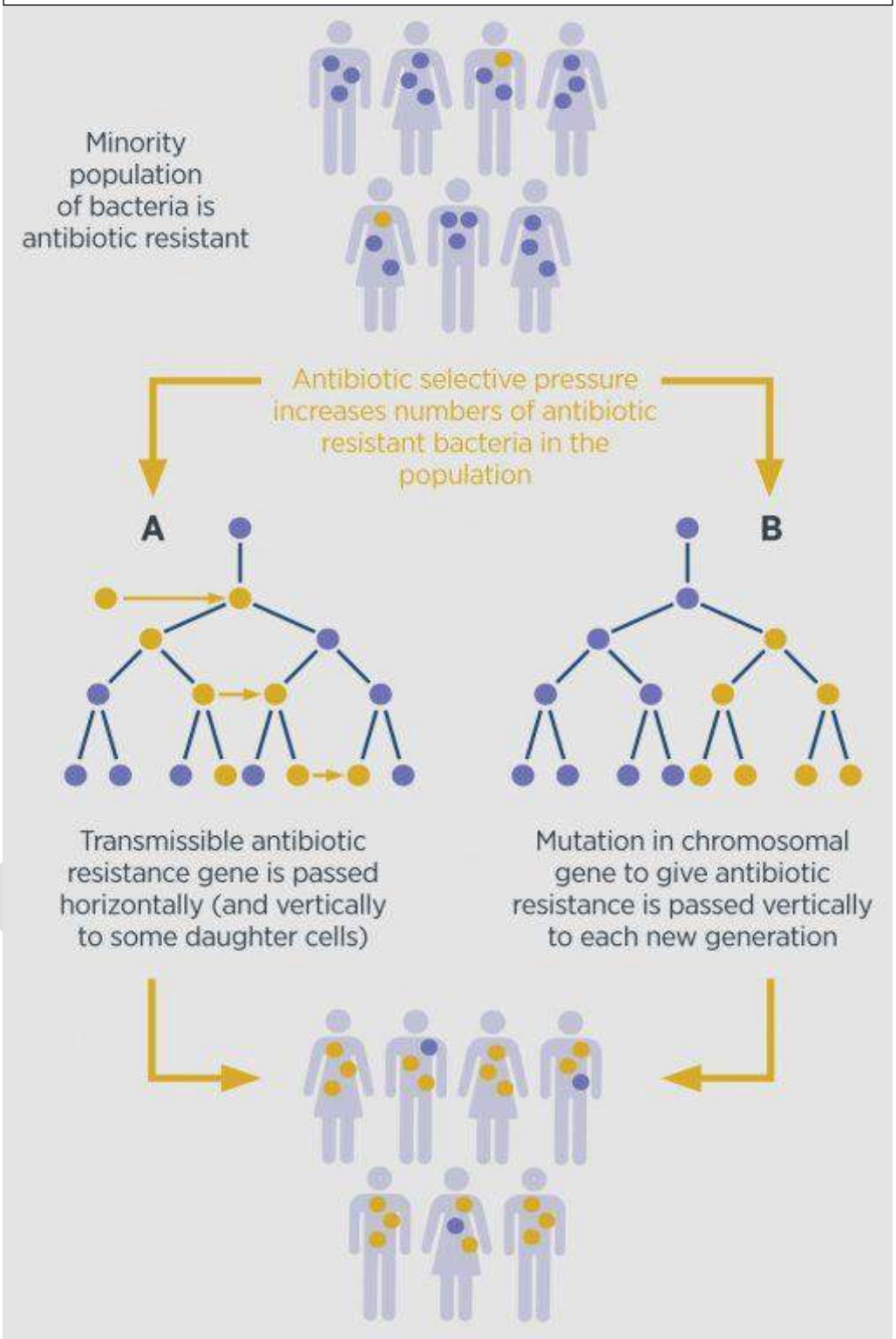
Over 500,000 people die worldwide every year from antibiotic resistant infections.

Do we understand antimicrobial resistance?

Antimicrobial resistance occurs as a natural biological phenomenon. It develops when bacteria are exposed to the antimicrobials, through a process of natural selection where the bacteria which are immune to the antimicrobials are the ones that survive. They then pass on the resistant genes. This process speeds up with repeated exposures.

The spread of antibiotic resistance in populations is further illustrated in Figure 1.

Understanding the growth and transmission of antimicrobial resistance

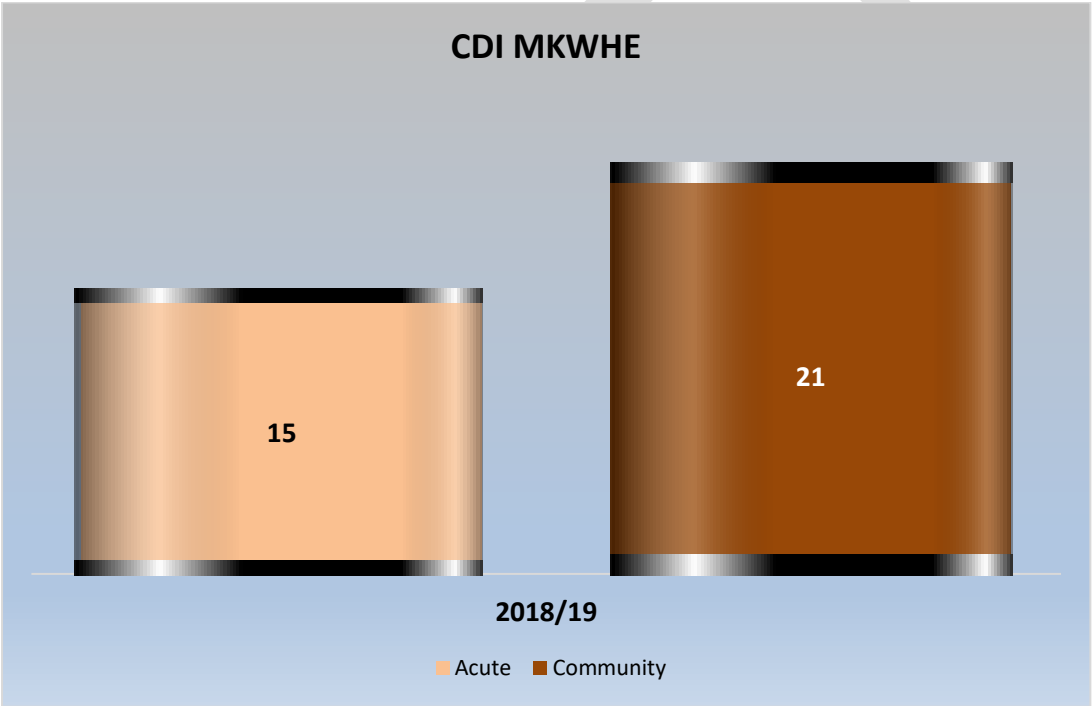


Clostridium difficile (CDI) – our cases in 2018/19.

Fifteen cases of CDI have been reported as attributed to the MKUH. Patients have an age range of 11 – 95 years, with a fairly equal split between the genders, all have chronic co-morbidities.

The definition of hospital associated CDI from April 2019 will be those patients that test positive at 48 hours following admission, altering from 72 hours to come in line with all other nationally reportable organisms. (MRSA, MSSA, E. coli etc.)

All cases have been found to be unavoidable and therefore not representative of lapses in care, by our local C. difficile investigation panel within the Milton Keynes Clinical Commissioning Group (MK CCG). The CCG employ the Public Health England criteria to assess each case.

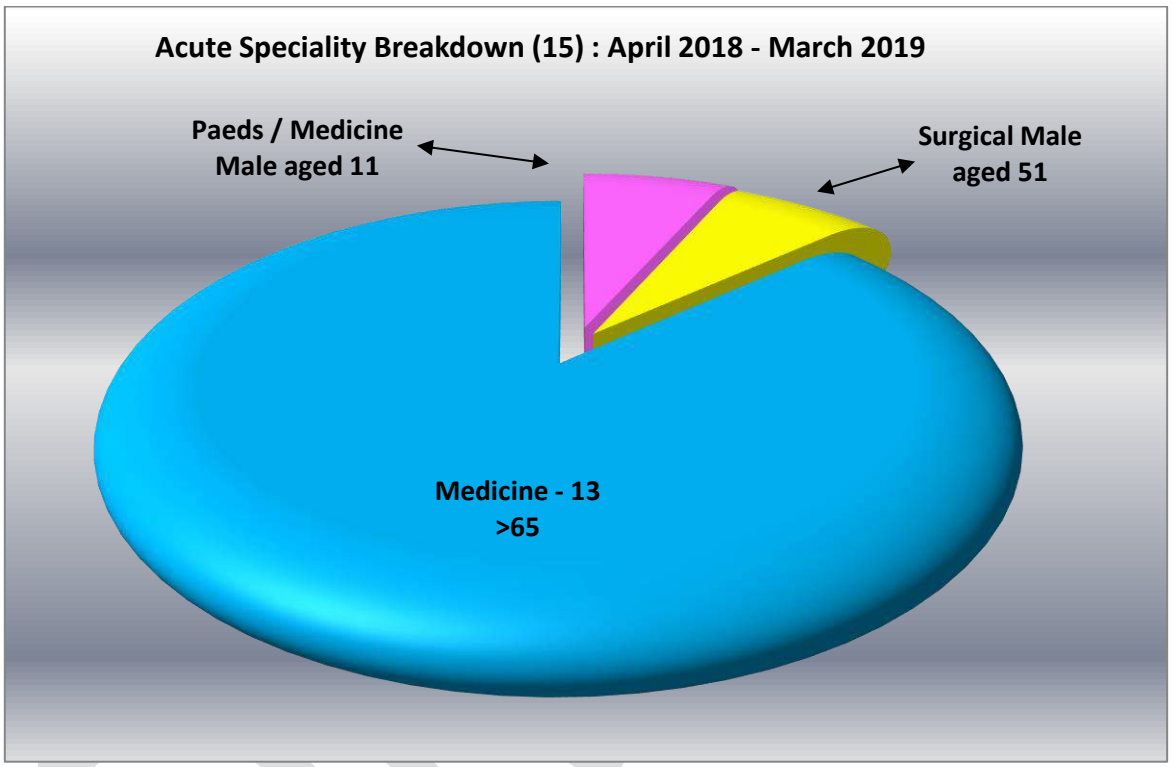


Objectives for next year have been set using the CDI figures from April to December 2018. This data has been annualised and a count of cases calculated for each clinical commissioning group (CCG) and NHS acute provider using new case assignment definitions.

The focus has now shifted with CCGs having responsibility or accountability for delivery of reductions in the total number of cases assigned to them.

The changes to the CDI reporting algorithm for financial year 2019/20 are:

- adding a prior healthcare exposure element for community onset cases
- reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.



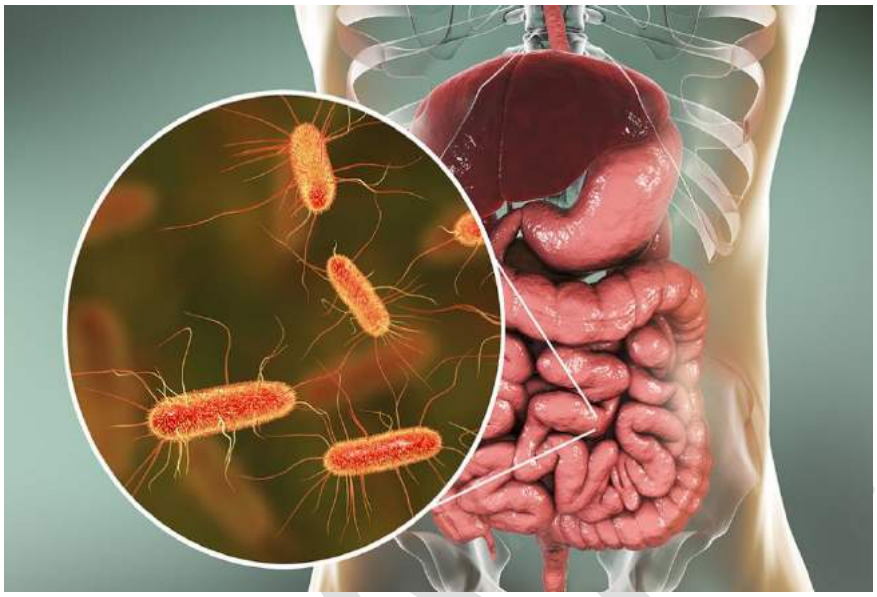
↑ **Graph showing *Clostridium difficile* case age/gender and speciality.**

Escherichia coli (E. coli)

This is a species of bacteria prevalent in the healthy human gastrointestinal tract and is in the main non-pathogenic.

The number of strains in the gut is described as diverse and the interest in understanding the role of the resident, non-pathogenic *E. coli* in resisting and recovering from incoming pathogens and or exposure to antimicrobials is growing.

3D illustration showing anatomy of human digestive system and enteric bacteria Escherichia coli.



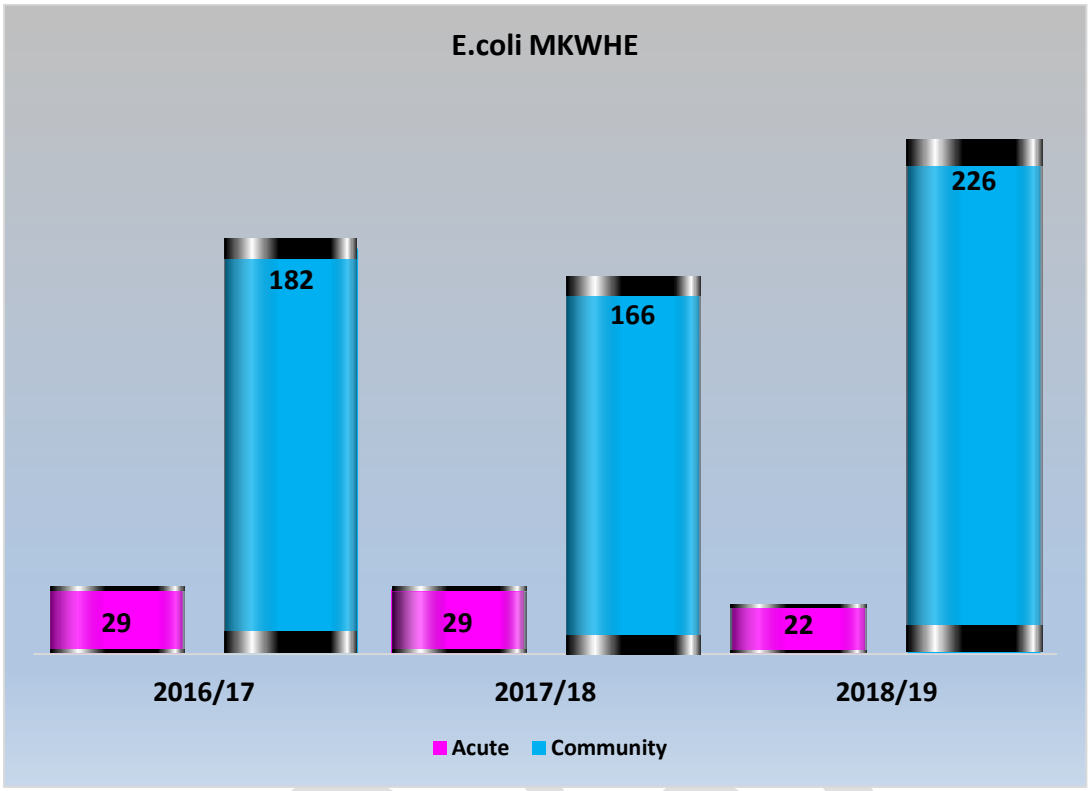
Our efforts to reduce E coli blood stream infections (BSI) and investigations into those cases has bettered our understanding of its association with a group of illnesses, including gastrointestinal and urinary tract infections as well as invasive disease.

E coli bacteraemia – have we met the national reductive obligation?

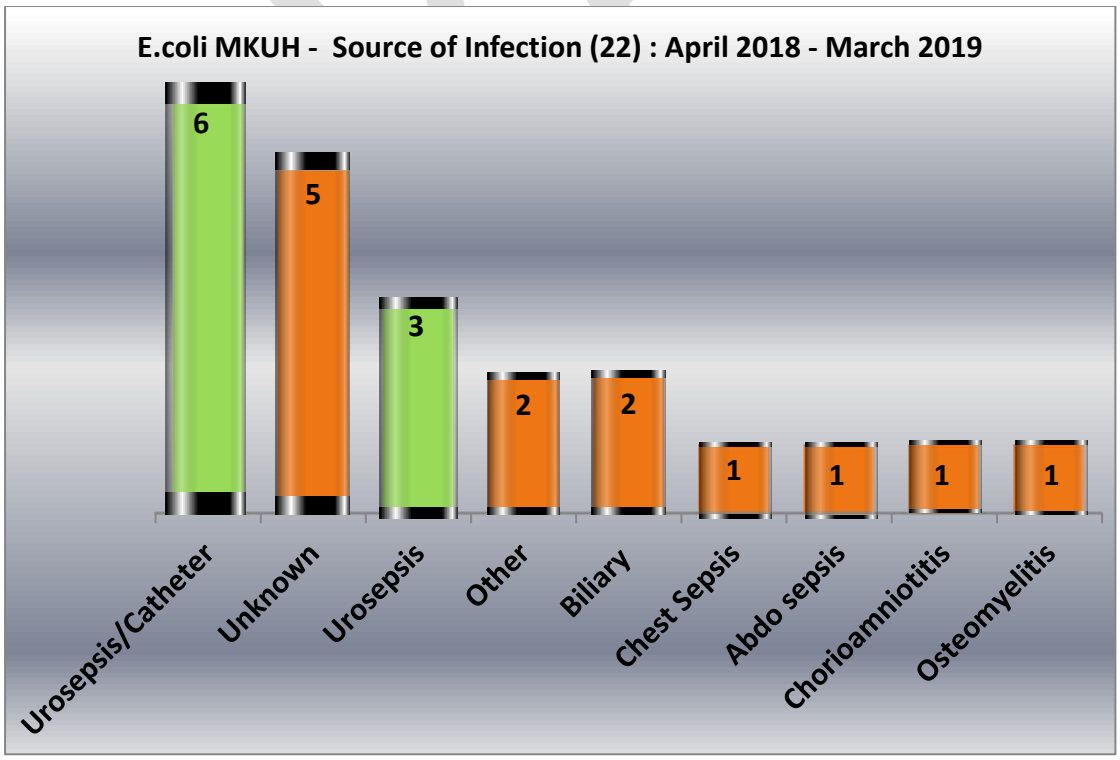
In May 2017, The Secretary of State for Health announced a focus on reducing Escherichia coli blood stream infections with an ambition to reduce the number of cases by 10% in the first year. As approximately **three-quarters** of Escherichia coli blood stream infections occur before people are admitted to hospital, a sustained reduction requires the whole health economy approach to stay focused.

The Infection Prevention and Control team have been collaborating with the MK Clinical Commissioning Group who are leading on achieving this target.

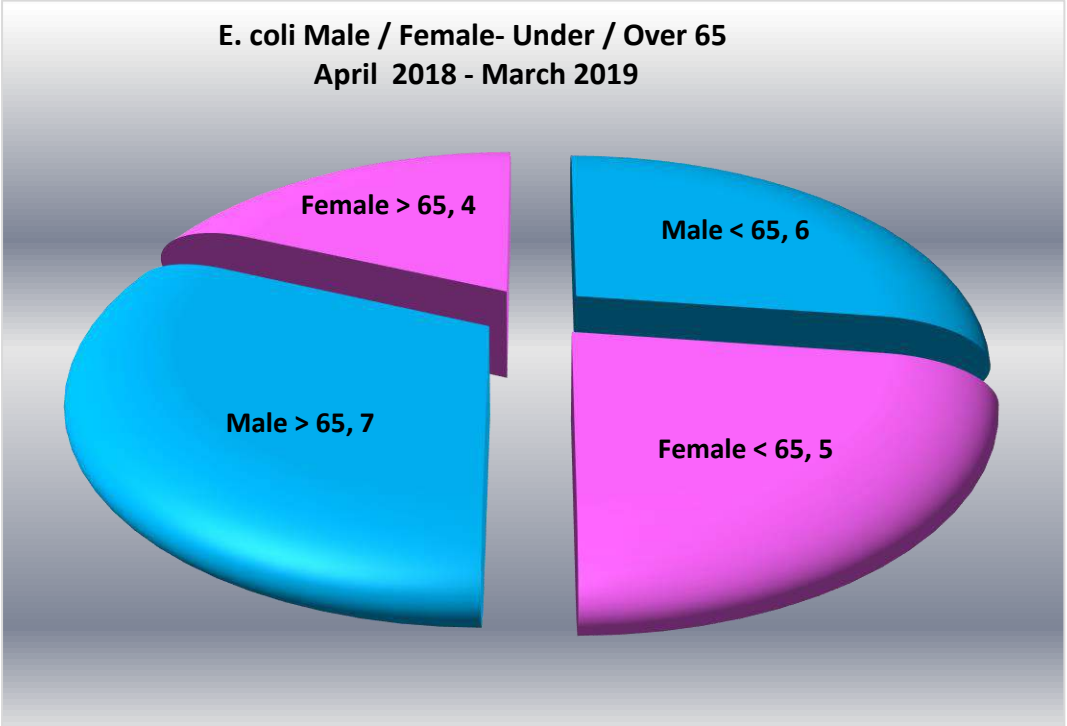
E coli data for the MK whole health economy (WHE) is shown here.



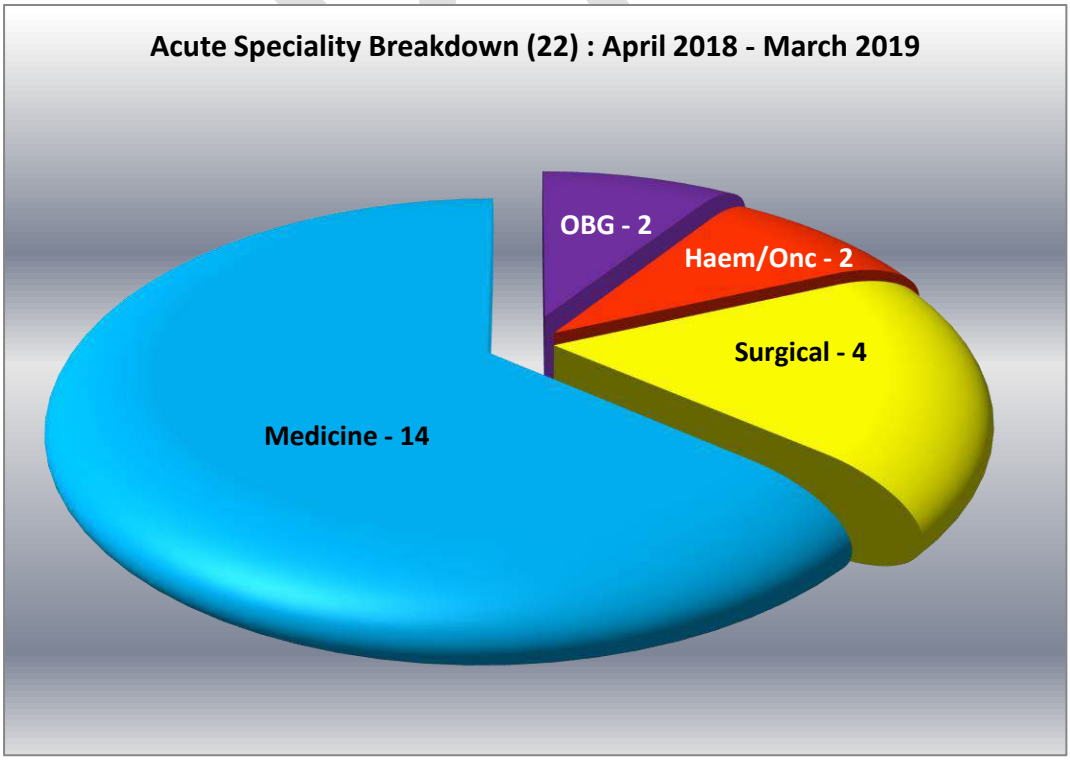
↑E. coli bacteraemia – present at admission in blue



E. coli cont.



↓ in-patient cases (obstetric/gynae, haematology, oncology)

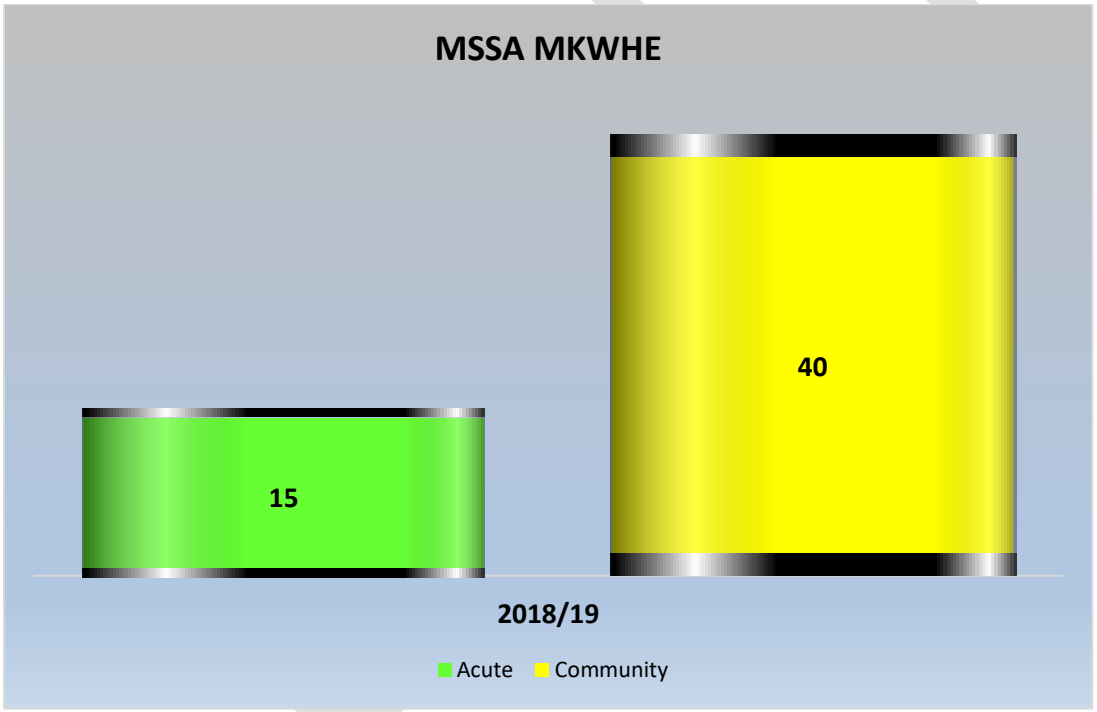


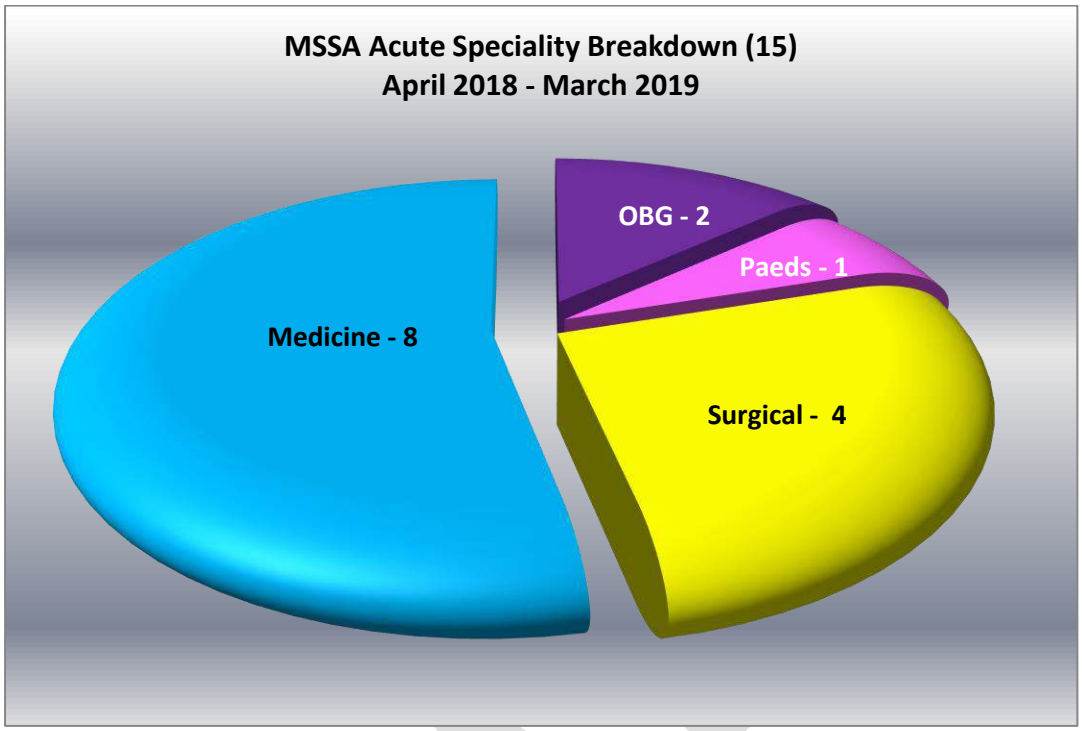
Meticillin Sensitive Staphylococcus Aureus (MSSA) Blood Stream Infection (BSI)

The national statistics for HCAI indicate MSSA BSI and *E*. *coli* BSI are rising at a similar rate, whereas a dramatic decrease and then a plateau in *C. difficile* infection and MRSA BSI now appears to be the norm.

Whilst there is some evidence of seasonality (greater during summer months) in E. *coli* BSI, the same does not apply to MSSA BSI.

At present, whilst we are asked by the PHE to report on 'Trust-attributed' (i.e. post-48 hour) or 'non-Trust-attributed' MSSA BSI there is no external threshold to reduce.





Klebsiella species bacteraemia (reportable to national database)

Klebsiella species belong to the family Enterobacteriaceae and are a type of gram-negative rod-shaped bacteria that are found in the environment and in the human intestinal tract (where they do not cause disease).

Two common species are associated with human infections: Klebsiella pneumoniae and Klebsiella oxytoca. Both are associated with a range of healthcare associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis. In healthcare settings, Klebsiella contagions are acquired endogenously (from the patient's own gut flora) or exogenously from the healthcare environment. Patient to patient spread can occur via contaminated hands of staff or less commonly by contamination of the environment. Air- borne spread of Klebsiella does not normally occur.

Pseudomonas aeruginosa bacteraemia. (reportable to national database)

Pseudomonas aeruginosa is a Gram-negative bacterium found in soil and ground water. It is an opportunistic pathogen that rarely affects healthy individuals. It can cause a wide range of infections, particularly in those with a weakened immune system, where contact with contaminated water is the likely cause.

In hospitals, the organism can contaminate devices that are left inside the body, such as respiratory equipment and catheters. P. aeruginosa is resistant to many commonly used antimicrobials.

The Trust has an established Water Safety Group (WSG) which reports to the Infection Prevention and Control Committee. Water sampling takes place as per national guidance and includes the detection of P. aeruginosa and Legionella species.

Quality improvement

The hospital surgical teams are engaged in several programmes, each offering a rich resource in terms of learning outcomes on a local basis in addition to a greater understanding of the variances in practice across the health sectors and improving patient outcome. On appointment of a data analyst to the IPCT, the surgical site infection surveillance programme was reinstated covering hip and knee replacement.

Surgical Site Infection (SSI)

Case definitions of Surgical Site Infection as per the national guidance from Public Health England (PHE). Their annual report (December 2018) shows trends in annual SSI incidence continue to vary by surgical category with hip and knee replacement surgery decreasing further from 0.6% and 0.5% in 2016/17 to 0.5% and 0.4% in 2017/18, respectively.

Superficial incisional (2 knee cases classed as superficial)

Infection occurs within 30 days after the operation and involves only skin and subcutaneous tissue of the incision and at least one of the following:

Purulent drainage with or without laboratory confirmation, from the superficial incision. Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision.

At least one of the following signs or symptoms of infection:

- Pain or tenderness
- Localised swelling
- Redness
- Heat and superficial incision are deliberately opened by surgeon, unless incision is culture-negative
- Diagnosis of superficial incisional SSI made by a surgeon or attending physician.

Deep incisional (2 hips & 1 knee case classed as deep)

Infection occurs within 30 days after the operation if no implant is left in place or within 90 days if implant is in place and the infection appears to be related to the operation and infection involves deep soft tissue (e.g. fascia, muscle) of the incision and at least one of the following:

- Purulent drainage from the deep incision but not from the organ/space component of the surgical site.
- A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least.

One of the following signs or symptoms:

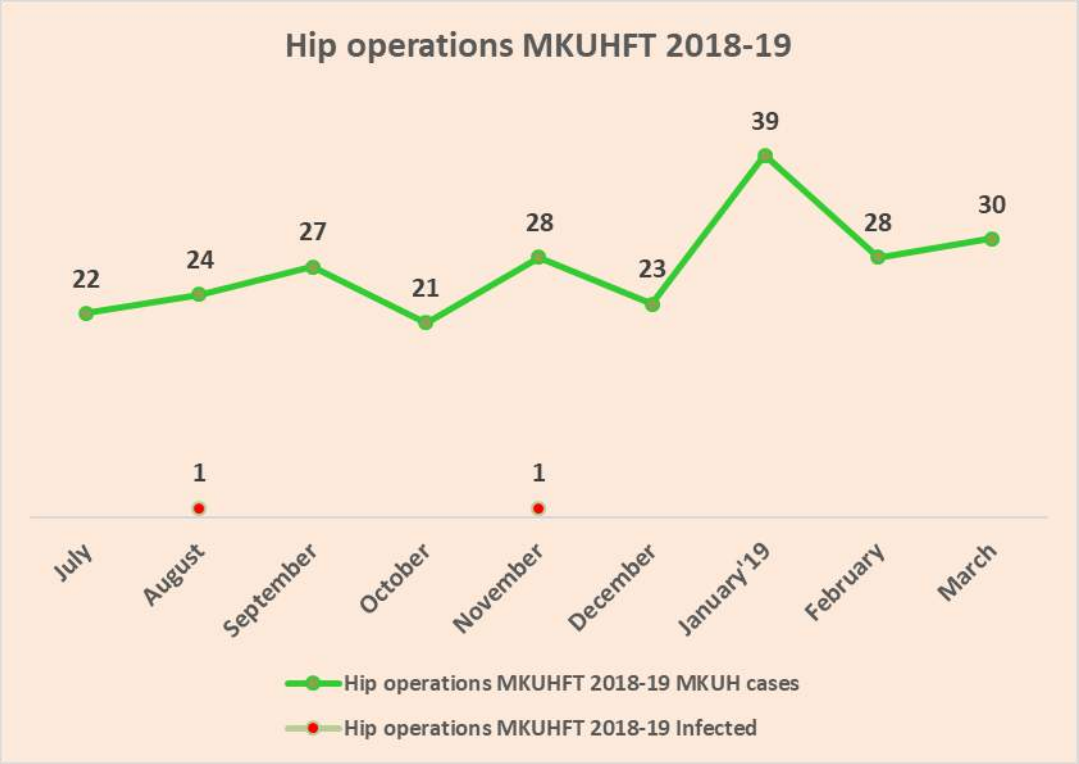
- Fever (> 38°C)
- Localised pain or tenderness, unless incision is culture-negative
- An abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination diagnosis of deep incisional SSI made by a surgeon or attending physician.

Organ/space

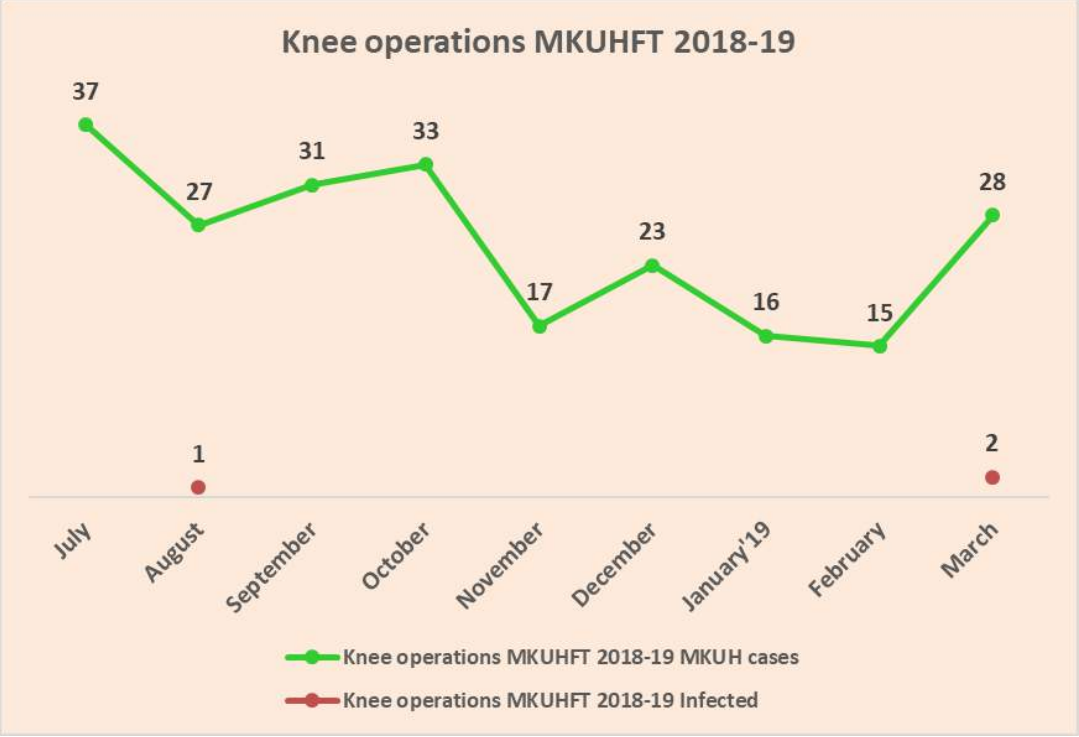
Infection occurs within 30 days after the operation if no implant is left in place or within 90 days if implant is in place and the infection appears to be related to the operation and infection involves any part of the anatomy (e.g. organs and spaces) other than the incision that was opened or manipulated during an operation and at least one of the following:

- Purulent drainage from a drain that is placed through a stab wound into the organ/space
- Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space
- An abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination diagnosis of organ/space SSI made by a surgeon or attending physician.

The following data relates to our Milton Keynes Hospital patients included in the SSISS programme from July 1st, 2018 – March 31st, 2019



↑ **Graph showing hip replacement operations.**



↑ **Graph showing knee replacement operations.**

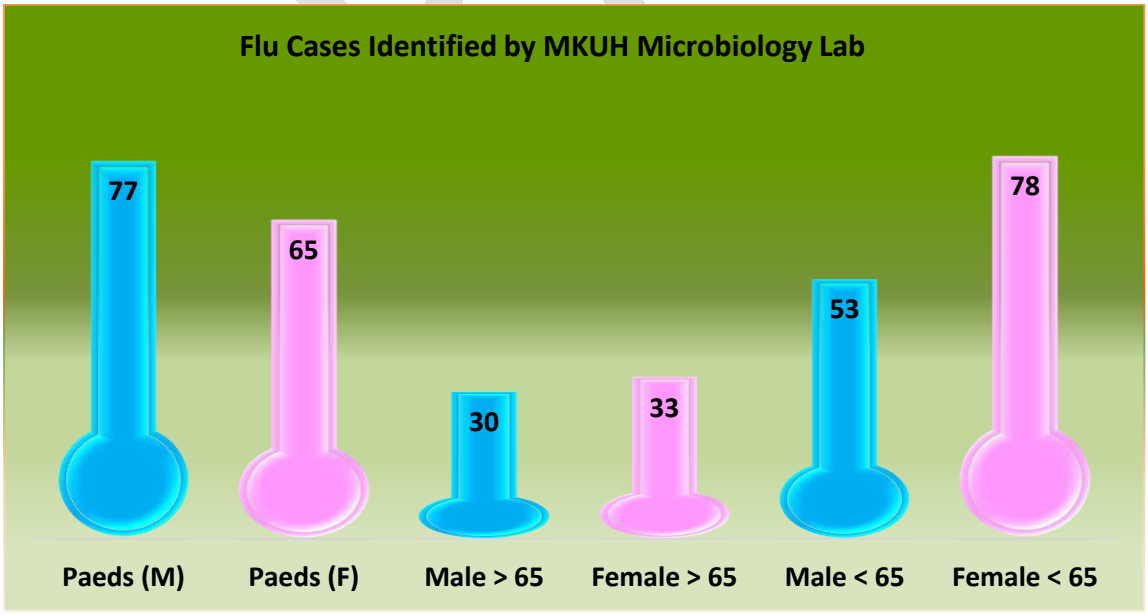
Outbreak avoidance

When we discuss our avoidance measures, we often consider the viruses that can impact on service delivery if they are introduced to our hospital such as gastroenteritis, for example norovirus and influenza type illnesses (ILI). We now employ the same approach if challenged by accepting just one patient suspected or known to be carrying a multi-drug resistant organism.

Influenza type illness (Flu) Our 'Flu vaccination process, uptake and subsequent success was driven by peer vaccinators encouraged to seek opportunities to vaccinate colleagues and to facilitate conversations with those staff unsure or with questions. The Staff Health and Wellbeing Team again provided clinics and attended Trust Induction to provide vaccine to new staff.

Increased support and communications regarding identification and management of influenza was in place and in addition;

- IPCT daily Flu briefing held to support the management of cases and contacts
- Information fed into the site team meetings
- Daily internal flu sitrep distributed
- Daily reporting to NHS England on cases of Flu A or B.
- 2019 planning for seasonal influenza will commence in May 2019. This will be fed into the Trust Pandemic Influenza Group meet.



Isolation and containment.

The hospital continues to make best use of isolation precautions and facilities. Observations of outbreak avoidance /management have demonstrated that policy is being adhered to, with prompt reporting of potential outbreak situations enabling frontline staff to utilise IPC advice at the earliest opportunity thus minimising the risk of extensive or prolonged outbreaks.

Clean Environment supporting Clean Hands.

We know that the main themes that influence the perceptions of cleanliness are often summarised under three broad headings: appearance of the environment; physical cleanliness and staff behaviour. We are also aware that HCAI is predominately considered a clinical issue by many, however a growing evidence base is showing the relationship between environmental cleaning and effective infection prevention.

The role of environmental cleaning is to reduce the number of infectious agents that may be present on surfaces and minimise the risk of transfer of micro-organisms from one person/object to another, thereby reducing the risk of cross-infection.

The Domestic Manager has overall sight of the level of training on all aspects of the job roles, including the Government National Colour Coding Scheme and compliance with the Health Act and the Hygiene Code.

The domestic teams believe that well trained personnel not only keep the cleaning standards high but also motivates and encourages them to take pride in their work. The Trust takes cleaning extremely seriously and independent audits (PLACE) have stated that the Trust maintains a high standard of cleaning.

Going forward, if we are to maintain our avoidance tactics in relationship to resistant organisms and the environment, then further significant investment in cleaning services will need to be realised to allow us to have cleaning staff on duty throughout the day on wards, as well as increasing resource availability for busy areas such as the emergency department, which requires 24/7 cover. We should also consider looking to increase the number of staff for cleaning emergencies.

The Trust conducts its own electronic monitoring system which produces a monthly report on all cleaning standards throughout the hospital. These scores are shared with all departments and scrutinised by the Infection Prevention and Control Committee.

Conclusion

The Infection Prevention and Control Team has made changes in the way that the service is delivered to meet the needs of the organisation and to be able to withstand external scrutiny. This is an evolving process and the transformation will continue as the IPCT progress.

We believe we hold a unique position that is underpinned by the individual and collective learning that is made available by the Hospital Infection Society, Public Health England, a multidisciplinary working group (BUG club) and other cross sector HCAI “fighting” agencies.

There is more we could be doing in terms of innovation and entrepreneurship through the application of new ideas, new tools, that whilst they can be disruptive in the sense that they overhaul the current way of working, they create possibilities that didn’t exist before.

IPC activity is not just about sustaining the all-important high-profile hand hygiene campaigns, it has to encompass the continuous provision of a safe environment (clean staff, wards, water, air and equipment), regular assessment of risk, and the use of standard precautions and specified protocols to reduce risk.

Have you pledged to “do your bit” to sustain the change on how we think and act about the hospital environment?

The Board is asked to note the progress to reduce healthcare associated infections in 2018/19 and approve the report for publication.

Financial Implication: Healthcare associated infections have a significant financial impact in terms of cost of treatment and extended length of stay.

There are no capital or revenue financial implications from this report.

References:

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Ovretveit J. (2009) Does improving quality save money? A review of the evidence of which improvements to quality reduce costs to healthcare service providers. London; Health Foundation p8

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NICE (2011) Prevention and control of healthcare-associated infections Quality improvement guide

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Meeting title	**Board of Directors**	**Date: 5 September 2019**
Report title:	**Annual Complaints Report**	**Agenda item: 5.4**
Lead director **Report author**	**Name: Nicky burns-Muir** **Name: Julie Goodman**	**Title: Director of Patient Care and Chief Nurse** **Title: Complaints and PALS Manager**
FoI status:		

Report summary	All Foundation trusts are required under the Local Authority, Social Services and NHS Complaints (England) Regulations of 2009 to report on how they have handled patient complaints during 2018/19, and how any lessons learnt from complaints has been disseminated across the organisation.			
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation				

Strategic objectives links	1. Improve patient experience 2. Improve patient safety
Board Assurance Framework links	
CQC regulations	
Identified risks and risk management actions	
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	Patient Experience Board and Management Board
Next steps	
Appendices	

SUBJECT Complaints Annual Report

DATE April 2018 to March 2019

REPORT BY Julie Goodman, Trust Lead for Complaints and PALS

Executive Summary

This is the Complaints annual report for Milton Keynes University Hospital NHS Foundation Trust (MKUH) for the period 1 April 2018 to 31 March 2019. MKUH serves a population of 261,750 (estimated) and this year received 88,041 attendees to the Emergency Department, 25,993 elective admissions, 34,401 emergency admissions, 383,036 outpatient attendances and delivered 3592 babies.

The National Health Service Complaints (England) Regulations 2009 state that all Trusts must prepare an annual report on the handling and consideration of complaints. This report provides detail of the required inclusions and will be made public on the Trust's website and sent to commissioners of the Trust.

These regulations are further supported by the publication of national reports including the Francis Report 2013, Clwyd and Hart Report 2013, Designing Good Together Parliamentary and Health Service Ombudsman (PHSO) 2013, and My Expectations for Raising Concerns and Complaints (PHSO) 2015 highlighting best practice in respect of dealing with concerns and complaints. Extensive analysis of the NHS England's toolkit - 'Assurance of Good Complaints Handling for Acute and Community Care - a toolkit for commissioners, has revealed that the Trust's Complaints service and process is robust and accessible to our public.

Systems and processes are in place within the Complaints and PALS teams to provide the Trust's commissioners with assurance that:

- All complaints are well managed
- The learning from complaints is identified and used for improvement
- The complaints service is accessible, open and transparent

Each and every complaint is an opportunity for the Trust to learn and make improvements in the areas that patients, carers and relatives tell us are important to them when using our services. We understand that handling concerns and complaints effectively matters for people who use our services and who deserve an explanation when things go wrong and want to know that a tangible change has been made to prevent something similar happening to anyone else.

In January 2015 the Health Select Committee MPS found that "In moving to a culture which welcomes complaints as a way of improving NHS services, the number of complaints about a provider, rather than being an indicator of failure, may highlight a service which has developed a positive culture of complaints handling".

Every complaint is triaged by the Deputy Chief Nurse and the Trust Lead for Complaints and PALS to ensure the appropriate investigation into the issues raised is undertaken.

The remit of PALS is to provide advice and information and guidance on how and where to complain and investigate matters of concern, and focus on resolving issues without the need for a formal investigation. Not every complaint needs to be resolved by investigation if the concerns are about current treatment where action can be taken quickly to resolve problems.

Formal complaints that require investigation of more complex and serious concerns are dealt with by the Complaints team.

Achievements

An internal audit of the complaints process was undertaken in December 2018 by RSM Risk Assurance Services.
Recommendations from the audit included:

- Adding the email address of the Complaints team to the Trust's internet site
- Improvements to the Complaints database, provided by DATIX, to include an audit checklist to ensure upon the closure of a complaint key information is recorded, the action (learning) tab within the database being updated to reflect the division assigned to undertake the action (learning), dates added to the database to allow for escalation of late investigation responses to be tracked
- Engagement with the divisional triumvirates on a weekly basis to ensure the division are fully sighted on their complaints and are made aware of any difficulties in obtaining an investigation response

All of the above actions have been completed. An action outstanding and rated as Amber is regarding complaints training for senior members of staff who have been promoted internally with the Trust. A system for capturing this information is currently being scoped in conjunction with the Human Resources department.

A very clear process is in place for the Complaints office which identifies key dates to be worked to and clear lines of escalation for any delays identified in the complaint's journey. A weekly RAG report detailing the current status of all complaints is shared with the divisional triumvirates and is used as a tool to improve performance. The Board receive a RAG report detailing those complaints that require escalation by an executive to obtain the division's investigation response.

The feedback gained from Complaints and PALS is triangulated with other patient experience feedback such as the Friends and Family Test (FFT), inpatient survey data, patient opinion websites such as NHS Choices and the 15 Steps Challenge to ensure any highlighted issues are dealt with promptly to ensure our patients go on to have a good experience.

The Trust Lead for Complaints and PALS and the Patient Experience and Engagement Manager meet with the senior staff on wards/departments on a rolling programme to highlight the feedback received for the area. This allows the area to consider what is going well and to make improvements to the experience of the patients where needed. Improvements in the last year as a result of these meetings are changes to information on wards in respect of photographs of team members and their role, distinct staff name badges to highlight the 'Nurse in Charge', obtaining of charitable funds to purchase radios for a patient's use.

The PALS office is located in the Main Entrance. This has ensured the PALS team is more accessible to all. There has been an increase in contacts with the PALS team of 34% when comparing 2017/18 to 2018/19. Within the same period the number of face to face meetings with callers to the service has risen by 154%.

To widen accessibility to the PALS service a mobile telephone number is now available to enable callers to text the service with their details to obtain a call back from PALS. During 2018/19, 72 contacts have used the text service.

Training on the complaints process and the PALS service is delivered across the Trust as requested by individuals and departments and a rolling plan is in place to ensure training is delivered to all areas. All staff who are new to the Trust and are Band 7 and above receive an invitation to meet on a one to one basis with the Trust Lead for Complaints and PALS to receive training on the complaints process and their role within that process.

At induction and in all areas of the hospital, a staff leaflet is available which details advice and help on how staff should handle a person who is making a complaint. This leaflet provides details of the Complaints and PALS teams for any advice that may be required.

Summary of NHS Complaints Procedures

In April 2009 the NHS Complaints Procedure was amended and the latest NHS (Complaints) Regulations came into force. The Local Authority Social Services and NHS Complaints (England) Regulations 2009 are a Statutory Instrument that all Trusts, including Foundation Trusts, have a duty to implement. Whilst the procedures are not prescriptive, the regulations set out various obligations on NHS bodies in relation to the handling of complaints. Since 1 April 2009, there has been a single approach across Health and Adult Social Care to dealing with complaints. The regulations set out a two-stage complaint system:

Stage 1 Local resolution – working with the complainant to understand and resolve their concerns in a timely and proportionate fashion.

Stage 2 Referral to the Parliamentary and Health Service Ombudsman (PHSO) – If local resolution is not successful and people are dissatisfied with the way their complaint has been handled, the complainant can refer their case to the Ombudsman for review.

The national complaints legislation requires that concerns raised by the public are responded to personally and positively and that lessons are learnt by the local organisation. The local resolution stage focuses on the complainant and enabling organisations to tailor a flexible response that seeks to ensure all complainants receive a positive response to their complaint or concern. It places an emphasis on resolving them as fairly and as quickly as possible and ensuring that lessons are learned and shared to improve the experience of care.

The Parliamentary and Health Service Ombudsman is a free and independent service, set up by Parliament. Their role is to investigate complaints where individuals have been treated unfairly or

have received poor service from government departments and other public organisations and the NHS in England. If local resolution is not successful, the complainant can refer their case to the Ombudsman for review. The Ombudsman makes the final decisions on complaints about the NHS for individuals. They use what they learn from complaints to help public services improve.

MKUH Complaints Process

The Complaints and PALS team aim to provide a person-centred approach to all comments, compliments, concerns and complaints received. The Trust actively encourage staff closest to the care and services being received to deal with concerns and problems as they arise so that they can be remedied quickly and be responsive to individual need and circumstances to improve the experience of the patient. Such timely intervention can prevent an escalation of the complaint and achieve a more satisfactory outcome for all involved. The Trust looks to encourage concerns and complaints and ensure that any lessons learnt are shared throughout the Trust and information is used to inform service improvements for our patients and public.

When dealing with complaints, the principles, as laid down by the Parliamentary Health Service Ombudsman (PHSO), should be taken into consideration and adhered to. The principles are as follows:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

Most importantly, the Trust should put the complainant at the centre of all that it does and ensure that they deal with their complaint in the way the complainant wishes. The Trust should not be deciding for the complainant how the complaint will be processed; the decision should be made in conjunction with the complainant.

A complaint is defined in the Trust's complaint policy as follows: -

"An expression of dissatisfaction about an act, omission or decision of the Trust, whether justified or not, which requires a response which cannot be given either straight away or by the end of the next working day"

Annual Complaint Figures

MKUH is organised into four divisions. These are Surgical Services, Medical Services, Women's and Children's Services and Core Clinical Services, each of which are led by a triumvirate team which includes a Divisional Director, Head of Nursing and General Manager who are collectively supported by Corporate Services.

The complaint numbers during 2018/19 have been collected for each division and the number and type of complaints received has been closely monitored and analysed in order to identify themes and trends and inform future improvements moving forward.

A total of 1415 complaints have been received by the Trust during 2018/19 as detailed on the chart below.

	Q1 Apr - Jun 18	Q2 Jul – Sep 18	Q3 Oct – Dec 18	Q4 Jan – Mar 19	**TOTAL**
Complaint Numbers	358	355	331	371	1415 (n = 1256 2017/18, **increase 12.65%**)

Source: DATIX Risk Management System as at 05/2019

The chart below details the number of complaints received compared to the total attendances to MKUH.

Year	Total Complaints	Total Footfall (Inpatient and Outpatient including A&E attendances)	% of complaints to footfall
2013/14	442	335953	0.13%
2014/15	613	375264	0.16%
2015/16	902	461713	0.20%
2016/17	838	502562	0.17%
2017/18	1256	503793	0.25%
2018/19	1415	535063	0.26%

As can been seen from the above information, the number of complaints received as a ratio to footfall has only slightly increased.

Responding

The following definitions are used to provide clarity about whether an issue of concern is handled within the NHS complaints procedure and to ensure that the Trust provides the most appropriate response:

Formal Complaint – A complaint can be defined as an expression of dissatisfaction with the service provided (or not provided) or the circumstances associated with its provision which requires an investigation and a formal response in order to promote resolution between the parties concerned.

Informal Complaint – An informal complaint can be defined as a matter of interest, importance or anxiety which can be resolved to the individual's satisfaction within a short period of time without the need for formal investigation and formal correspondence. Informal complaints are received by staff throughout the organisation. Where it has not been possible to resolve the complaint quickly (i.e. by the end of the next working day) and to the satisfaction of the person/s raising it, they will be asked if they would like their concern investigated as a formal complaint under the NHS Complaints Regulations (2009). All complaints whether resolved by the next working day or not, are recorded and reported and reviewed, collated and analysed along with the data recorded from complaints.

It is important that complaints are handled in accordance with the needs of the individual case and investigated fairly and proportionately.

The Trust follows the Department of Health guidance and legislation (the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009) which outlines the requirement to acknowledge all complaints within three working days. Under the current legislation Trusts have six months in which to resolve a complaint to the satisfaction of the complainant, providing a more flexible agreement with each complainant. MKUH aims to provide a response in as timely a manner as possible, working to an internal benchmark of 30 working days or 60 working days for complaints graded as Red (severe harm/death).

In order to ensure that people feel safe and supported to make a complaint, everyone is directed to additional information, advice and advocacy support. All complainants are signposted to the Parliamentary and Health Service Ombudsman (PHSO) (stage 2 of the NHS complaints process) in the case they are dissatisfied with the results of our investigation and complaint handling.

All complaints are dealt with in line with the Trust's complaints policy which includes an initial triage process to ensure complaints are investigated at the appropriate level and timeframe in relation to the severity of harm. The complainant is then contacted by the allocated complaint case officer to discuss the complaint in further detail and to gain clarity on their expectations from the complaints process. This includes gaining clarity on the issues they would like addressed and what they want to achieve as an outcome from the process, along with how they would like to receive the response, in writing or a meeting with responsible medical staff or both.

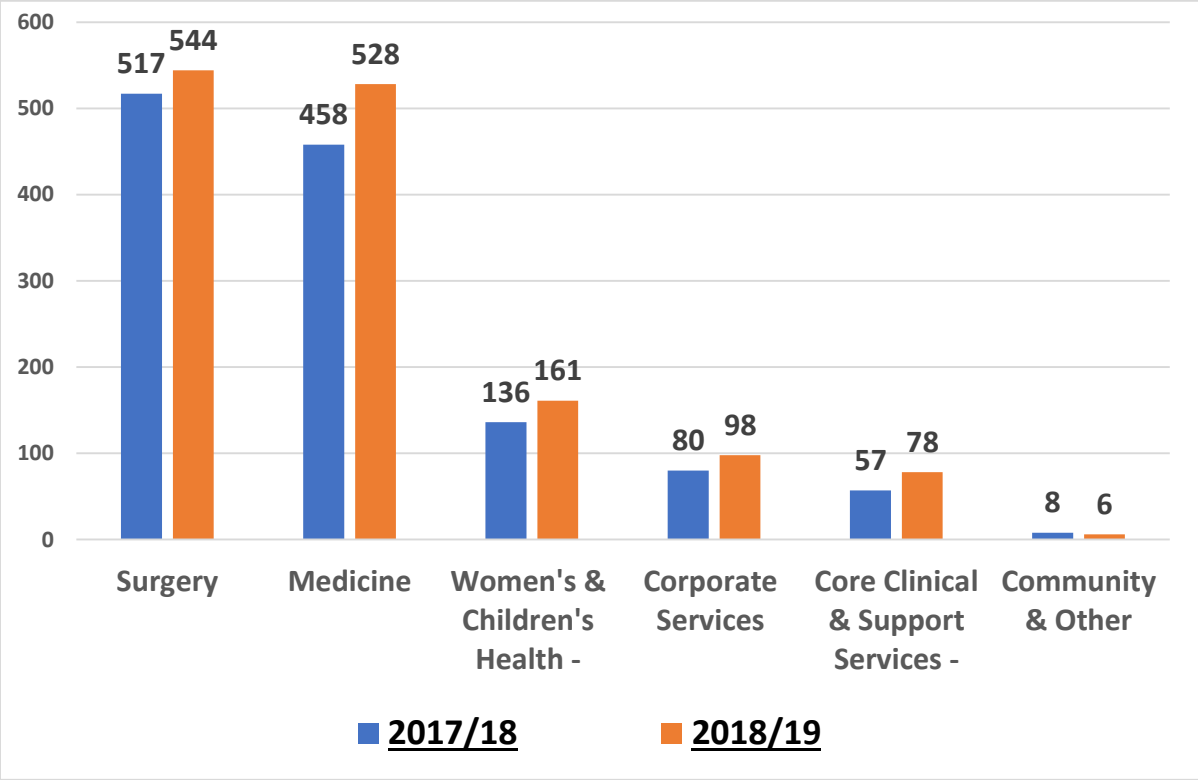
The 1415 complaints were represented across the divisions and are outlined in the table below with a comparison to the number of complaints received in 2017/18.

Complaint statistics

Complaints by division

The chart below compares the number of complaints received by division for 2017/18 and 2018/19.

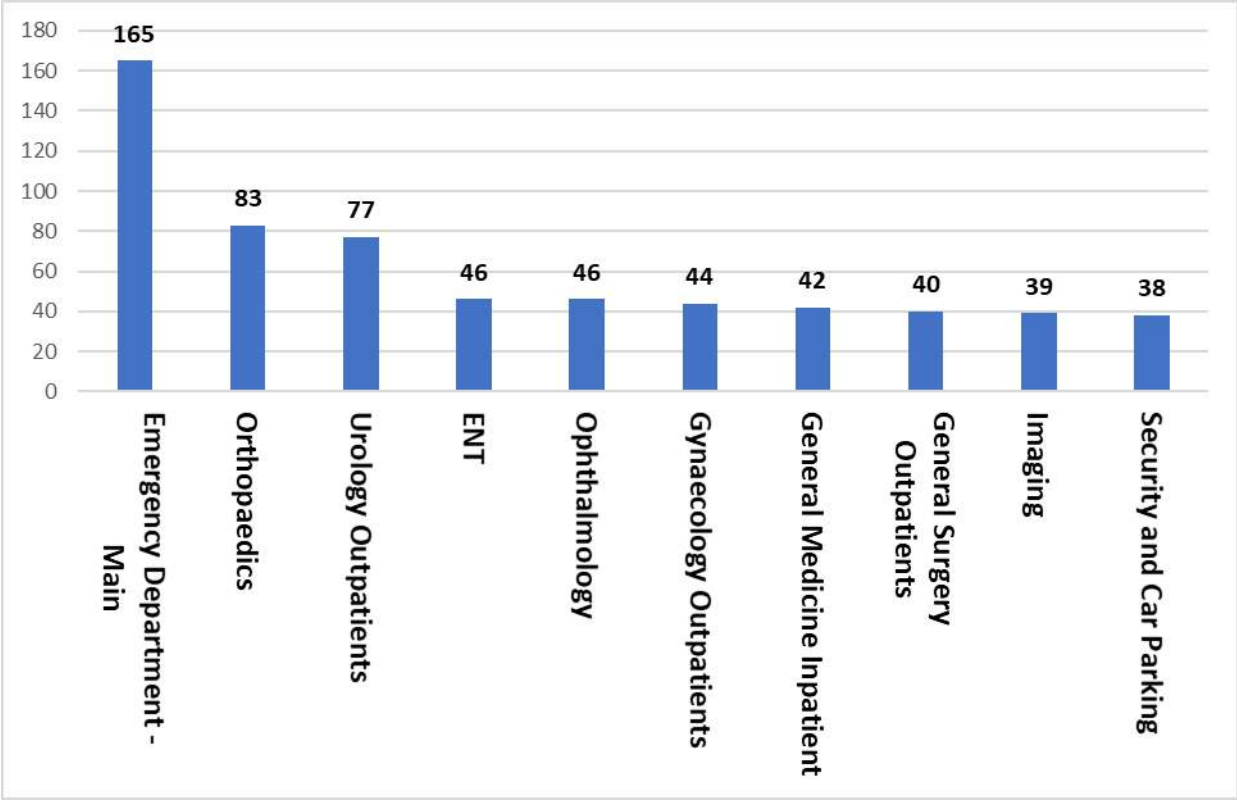
Chart 1 – Comparison of total number of complaints per division 2017/18 and 2018/19



Complaints by area

The chart below details the top 10 areas that have received complaints in 2018/19.

Chart 2 -Top 10 Complaint Areas for all Complaints 2018/19

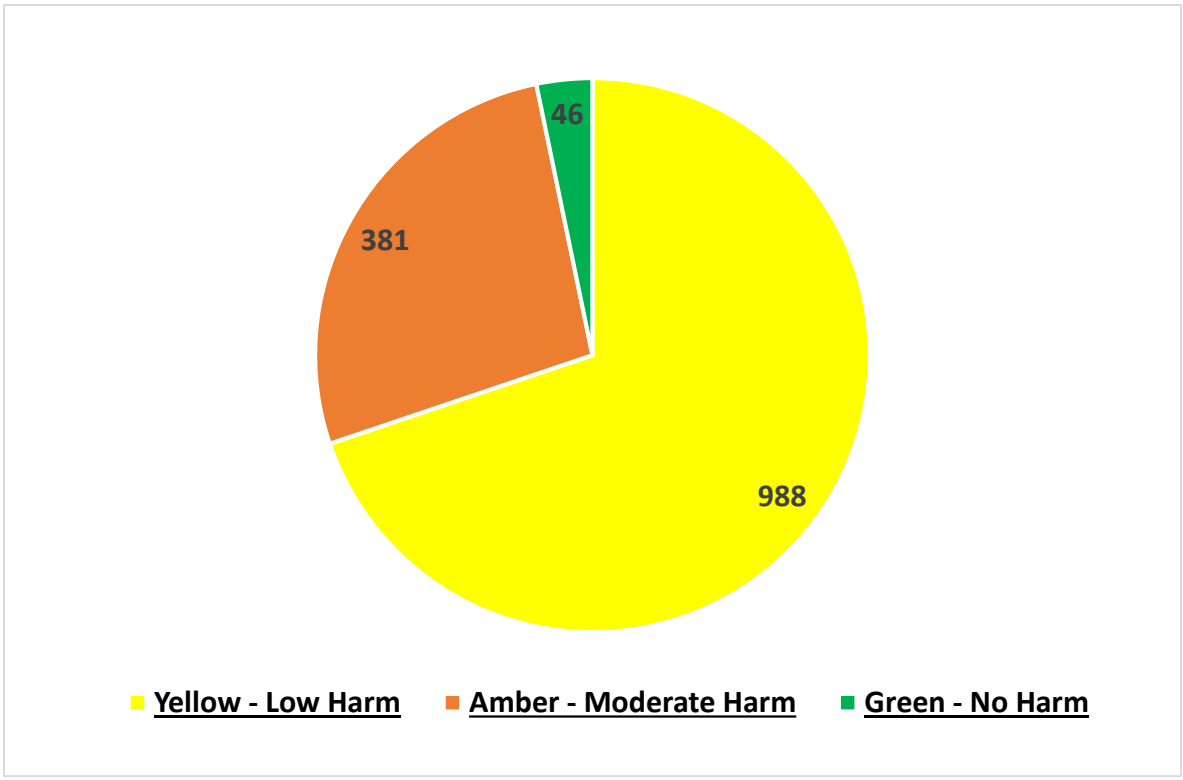


The top 3 areas for complaints remained constant in 2015/16, 2016/17 and 2017/18 and 2018/19. The new areas to appear for 2017/18 in the top 10 are Gynaecology outpatients, Imaging and Security and Car Parking.

Complaints by Severity in 2018/19

The chart below shows the number of complaints received by severity.

Chart 3 – Complaints by severity



As can be seen above, most complaints (73%) are low or no harm complaints and these are dealt with informally. This percentage as remained consistent across the last three years.

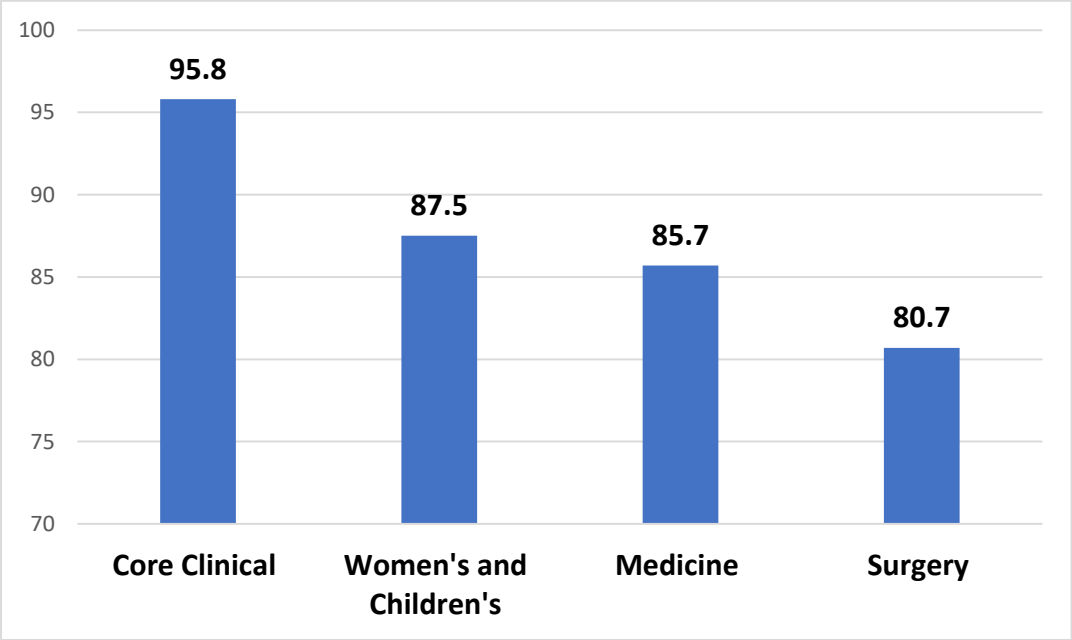
Each category has associated timescales in which to respond to the complainant as follows:

Green and Yellow (No and Low Harm)	15 Days
Amber (Moderate Harm)	30 Days
Red (Severe Harm)	60 Days

Responding

The chart below details the number of complaints responded to on time per division in percentage terms for 2018/19

Chart 4 – Complaints responded to on time per division in percentage terms

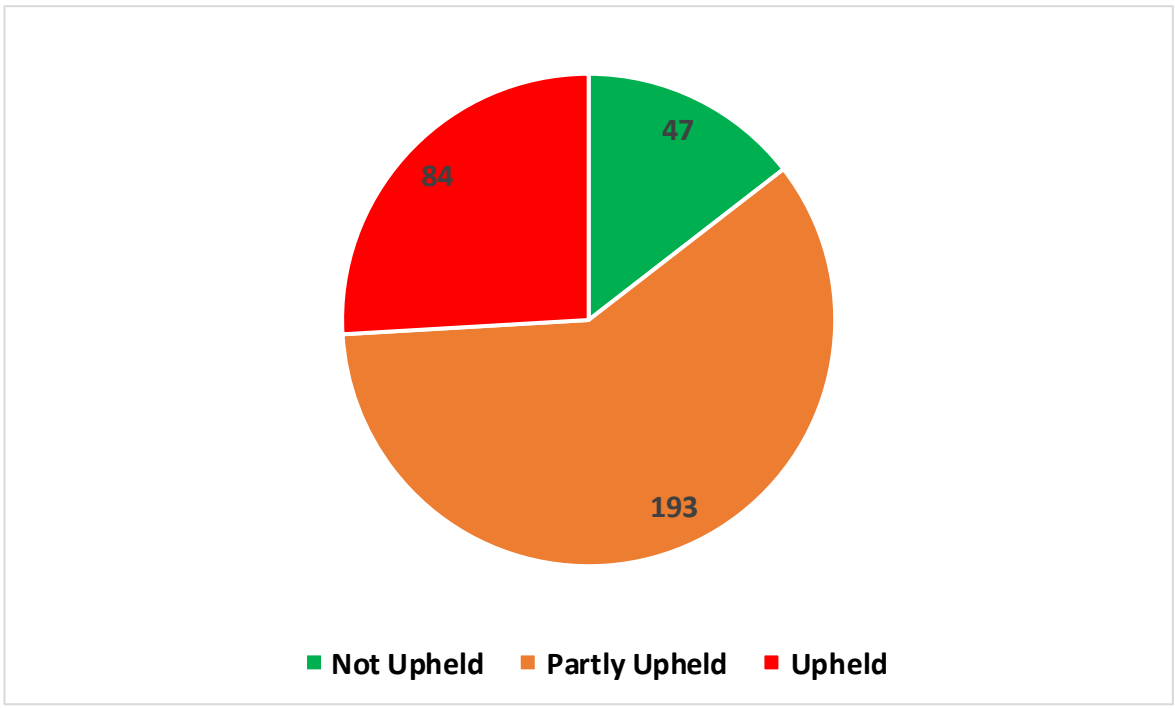


In 2018/19, Trust wide, 84.1% of complaints were responded to on time which is a decrease in performance from 2017/18 of 3%. The delays in responses can be attributed to some of the more complex complaints. It remains a challenge across all divisions to achieve the required response timeframe particularly at times of increased clinical pressure. Many of the complaints closed outside of the agreed timescales were either complex, which involved more than one service area or organisation, or those which raised additional issues during the investigation and complaint handling. A robust escalation process has been put in place during quarter 4 2018/19 in recognition of the difficulties that have been encountered in obtaining timely investigation responses from some areas. This involves escalation to the relevant executive lead when the escalation process has been exhausted by the complaints and PALS teams.

Complaints by outcome

The chart below shows the number of moderate harm complaints upheld, partially upheld or not upheld (taken from those that were resolved as at 01/04/2019). There were 383 moderate harm complaints received in 2018/19 and during this year there were no severe harm complaints.

Chart 5 - Moderate Harm Complaints Outcome 2018/19



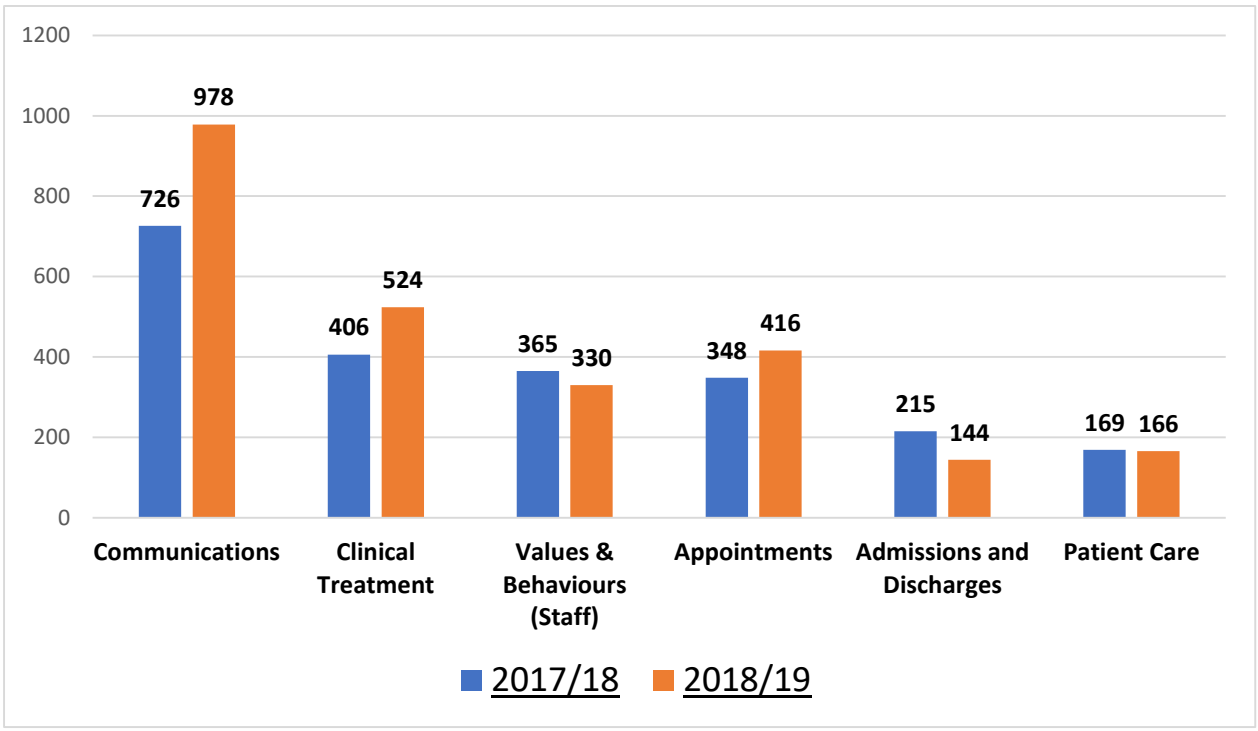
Category of Complaints

Complaints are recorded and categorised to help the organisation identify themes and trends and identify improvement actions in response to the findings.

Each issue reported in a complaint is logged onto the complaints database (DATIX) using the category it pertains to. Some complaints have more than one issue and to ensure a true reflection of issues encountered all issues are recorded.

The chart below gives a comparison of the top 5 categories of all complaints 2017/18 and 2018/19.

Chart 6 – Comparison of top 5 categories

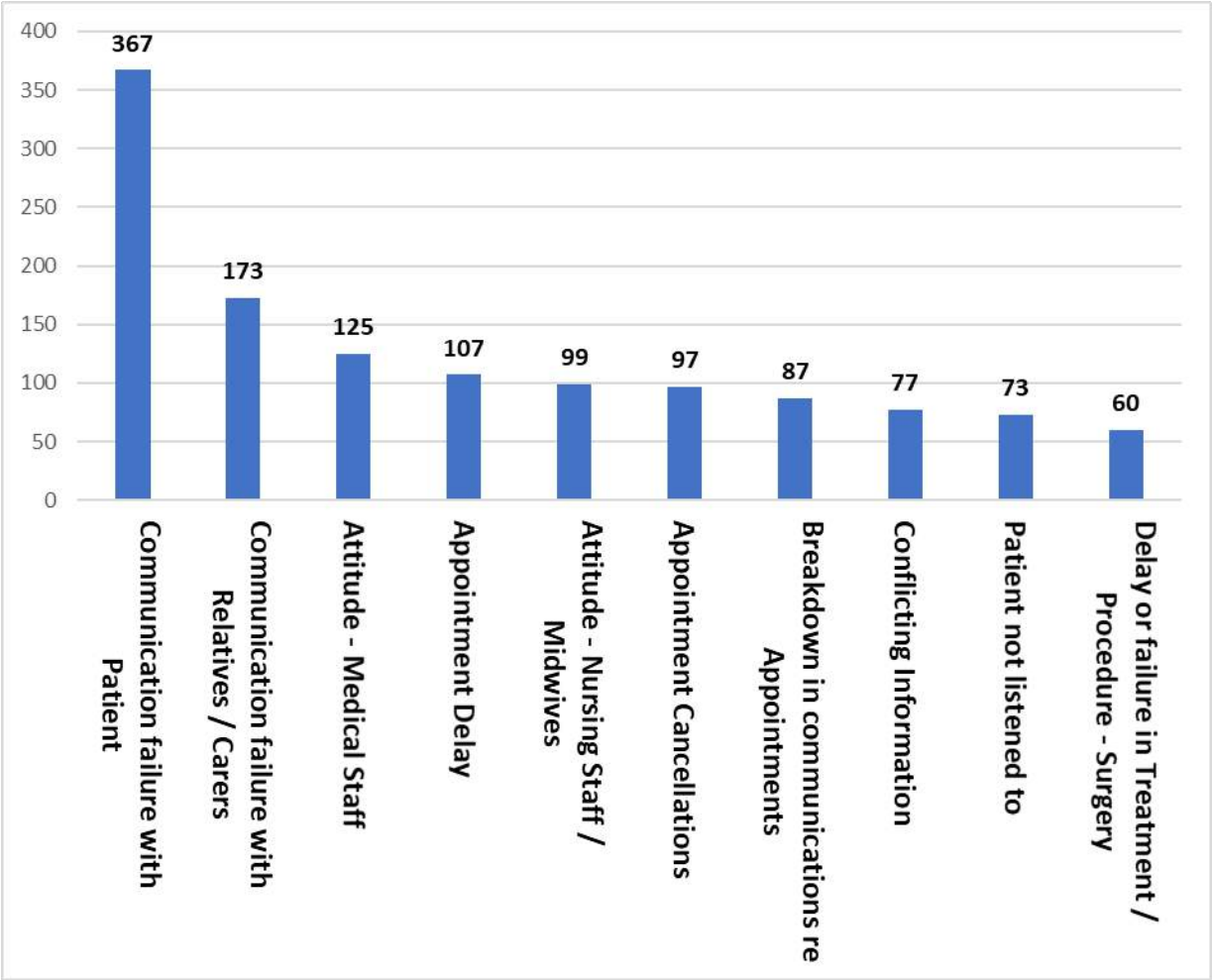


Communication, clinical treatment, appointment issues and staff behaviour and attitude account for the majority of the Trust's complaints for 2018/19 with this position not having changed when compared to 2017/18. Admission and discharges appeared in the top 5 categories in 2017/18 and this has been replaced by patient care for 2018/19.

Complaint issues – Top 10 2018/19

Below is a breakdown of the top 10 complaint issues for 2018/19

Chart 7 – Top 10 issues



With the exception of 'Delay or failure in Treatment/Procedure-surgery' all other issues were in the top 10 for 2017/18.

In respect of complaints raised regarding staff behaviour and attitude, over the last two years staff involved have been asked to ensure that they undertake a reflective piece of work following receipt of a complaint. This reflection should be shared with their manager/mentor to confirm that there has been learning as a result and they understand the effect that their behaviour has had on the person's experience as a whole.

If, during the complaint investigation, issues of a serious nature come to light the Chief Nurse or Medical Director are made aware and their advice sought.

Internal monitoring

The numbers and subjects of complaints are shared with the Trust in the Complaints and PALS report which is shared with the Board every quarter.

Governance Groups are provided with a summary of complaints for each CSU by their Governance Facilitator. The summary encompasses details of all complaints received for the service and more information on an individual service can be obtained from the Complaints and PALS team who will be able, using DATIX, to drill down to the finite detail of complaints received by area and subject. The Medical Director/Chief Nurse and the appropriate Clinical Directors and CSU Leads receive copies of all relevant complaints.

Reopens

If a complainant remains unhappy with the response to their complaint, they are encouraged to return to the Trust with their outstanding issues. These files are reopened and further investigation, if required, takes place with the final resolution taking the form of a meeting with the complainant or a further written response. The re-opening of a file takes place to enable the Trust to understand why a complainant is unhappy with their initial complaint response and to ensure that any outstanding issues are dealt with in a timely manner and this performance can be measured.

The number of complaints that have been reopened for further investigation in this year amounted to 132 (9.3%). This is a slight decrease in performance when comparing the reopens from 2017/18 (8%). There is no national guidance regarding the re-opening of complaints and therefore no benchmarking either locally or nationally is available.

Complaints and the Parliamentary and Health Services Ombudsman (PHSO)

If a complainant is dissatisfied with the way their complaint has been dealt with by the Trust and local resolution of their complaint has not been satisfactory, the complaint can be brought to the attention of the Parliamentary and Health Service Ombudsman (PHSO) for independent review. The PHSO will request copies of complaint files and medical records and any other relevant documentation to enable them to fully consider how the complaint has been dealt with and if there is anything further the Trust should do to address the complaint.

During this year 6 (0.42%) complaints have been reviewed by the Parliamentary Health Service Ombudsman (PHSO). This is an improvement on performance compared with 2017/18 (0.64%).

Of the 6 complaints referred the following decisions were made:

- 1 was partially upheld
- 5 are still under investigation

The information below relates to the partially upheld complaint and all actions indicated have been completed and evidence supplied to the PHSO

Medicine

Issue upheld	PHSO recommendations and action taken
This was in relation to care the Trust provided in 2013 and a complaint investigation which took place in 2014.The PHSO felt that the Trust had not listened to the patient's family in respect of their concerns regarding the patient's nutrition and also the complainant was not kept informed throughout the complaints process.	The Trust were required to provide an apology in writing to the complainant to include details of the actions taken as a result of the PHSO's investigation. The actions were as follows: - • The Dietetic team to deliver specific Malnutrition Universal Screening Tool (MUST) training to the ward nurses. This is a dedicated 6-8-week programme delivering 'bite size' teaching sessions on the wards. Included in this training is advice detailing what to look out for in terms of malnourishment, as it is recognised that the screening tool may not pick up all cases, and that feedback from families is a crucial part of this and this is emphasised within this training. • In addition, the dieticians have produced a guide for staff which will be displayed in all kitchens advising on appropriate snacks to offer patients who are felt to possibly be at risk of malnourishment. These include milky drinks, crackers and cheese, high fat yoghurts, biscuits and cakes. These items are now available in all ward kitchens. • In terms of monitoring the inclusion of family concerns regarding malnourishment, it was recognised that, at that time, a formal tool to measure this was not available. The completion of MUST scores is routinely audited on a monthly basis which is quantitative data. Moving forward with the use of Senior Sister rounds and Matron rounds on the ward areas, it is expected that comparisons will be made regarding the current MUST score of a patient and the clinical picture of the patient at that time, taking into consideration family feedback.

	This will provide qualitative data and a sample will be formally collected every quarter for a year (10 patients per adult ward) and reported to the Nursing and Midwifery Board.

During the year 2018/19, 2 complaints sent to the PHSO in 2017/18 were returned to the Trust and partially upheld.

The information below relates to those the complaints from 2017/18 which were partially upheld in 2018/19, all actions indicated have been completed and evidence supplied to the PHSO.

Maternity Services

Issue upheld	**PHSO recommendations and action taken**
This complaint was in relation to care provided by the Trust in 2013 and a complaint investigation which took place in 2014. The PHSO found failings in the decision to try and inhibit labour and thereby delay the delivery of a second twin. It was acknowledged that there is no guidance regarding what should have happened, but the risks in the actions taken by the Trust outweighed the benefits. On the balance of probabilities, the PHSO found that it was more likely than not that the second twin was delivered in a poorer condition than might otherwise have been the case. This increased the risk of her suffering complications and therefore reduced the chance of a successful outcome. The PHSO also found failings in the way the Trust handled the complaint.	The PHS0 recommended the following actions: - • Write to the complainant acknowledging the failings, as above, and apologise for the impact of the failings. • The Trust to produce an action plan explaining how it would ensure similar failings in respect of the action to try and inhibit labour do not occur in the future. • Make a good will gesture payment to the complaint in recognition of the failings

Emergency Department (ED)

Issue upheld	PHSO recommendations and action taken
This complaint was regarding care provided in 2014 and a complaint investigation which took place in 2015 The PHSO noted failings within the ED regarding a patient presenting to the ED with symptoms of abdominal pain and potential leaking AAA and for the symptoms to be more thoroughly investigated. The PHSO also found failings in relation to the provision of copies of medical records.	The action required was to provide an apology to the complainant for the failings identified. Other actions included: - • A Clinical Pathway being put in place with regard to potential leaking AAA, a flowchart is also in place to remind staff of pathway. • With regard to medical record requests, the request form has been made clearer, the urgency in which forms detailing a request for medical records is forwarded to information governance is reiterated in mandatory training re information governance and a SOP in place for the timely copying of medical notes following receipt of a request.

PALS activity

The PALS team deal with calls from the patients and the public requesting information, advice or needing signposting to a particular organisation or department, or need re-directing to other organisations.

The number of calls in this respect for the year 2017/18 with a comparison for 2015/16, 2016/17 and 2017/18 is shown in below.

	2015/16	2016/17	2017/18	2018/19
Feedback	194	142	77	112
Information	550	1072	960	1262
Signposting	110	284	460	710
Total	854	1498	1457	2084

Lessons Learned and Actions Taken from Complaints

The Trust values the opportunity that each complaint brings to learn and improve and recognises the importance of sharing the learning from complaints across the organisation for the benefit of our patients and staff. We continue to strive to demonstrate the changes that have been made as a result of the learning from complaints and to sustain the changes for long term improvement.

We act on feedback to make improvements to our services wherever possible. Details of lessons learned, and actions taken are inputted on DATIX. For every action mentioned in the response to the complainant, evidence of the action has to be given by the member of staff involved.

There have been many actions for complaints this year across the CSU's including:

- Dissemination of lessons learned/shared learning - by discussion at staff meetings, one to one supervision for reflection and reiteration of correct practice to individuals or groups of staff
- Processes/Procedures/Guidelines/Policy - amended/review or new
- Audit
- Patient information leaflet – new
- Improvement of facilities
- Staff training, individual/group

A small selection of lessons learnt are summarised below to illustrate how complaints may drive service improvements.

Our Patients/Families "Said"	We Did
The birthing pool could not be used due to the need for continuous monitoring of the baby's heartbeat	*Cordless monitors to be made available*
There were delays in the discharge prescription process	*A review of the process to understand the internal delays*
There was not a consistent approach regarding the care for women if they had a wound had broken down	*Pathway for wound are to be improved*
Pain was not being controlled	*A personal pain protocol was put in place*
There were drug errors, prescribing issues, omission or lateness of medication in Paediatrics	*A task and finish group was set up to review issues*
Patients were not made aware that they needed to bring a chaperone with them to be present at the beginning of the Oral Surgery appointment	*Patient information leaflet amended to reiterate the requirement of a chaperone*
No advice was given with regard to the management of a sprain	*A patient information leaflet was devised especially advising patients to return to hospital if their symptoms persist*
When the Day Surgery Unit was used as an escalation ward, patients were not given any information or explanation	*A patient information leaflet with all necessary information was devised and a review of the checklist*
Relatives not communicated with when patient had left theatre and still in recovery	*Implement a text service to inform the Next of Kin where in the pathway their relative was*
When patients left the hospital after being particularly unwell following surgery, they did not receive any communication from the hospital following discharge	*A telephone call is made by the ward to the patient the day following discharge*
ECGs of a baby and mother were muddled up	*Babies to have their own ECG folder and sticker whilst on the cardiology ward*
A baby's paediatric check was not undertaken since the baby had moved with its mother to another ward	*The paediatric handover sheet had another column added to it to highlight whether or not the paediatric check had been undertaken*
Calls in the Eye Clinic were not being answered	*A review of the administration systems in the clinic was undertaken*
Nurse were using their personal mobile phones whilst on the ward area	*A handout was devised for all staff. Especially temporary staff, to ensure staff were aware of their roles and responsibility re mobile phones*
End of life care was not explained to the family	*Palliative Care team to provide training to staff*
Families and patient did not understand who the senior staff were	*The senior nursing team's details are on each ward's information boards*
Not all nurses knew how to care for a patient's stoma bag	*Staff offered refresher training with the Stoma nurse*
Integral stands on trolleys used in the ED were either broken or missing	*A business case was put together to replace the integral stands*
Staff were not aware when a patient with a learning disability was on the ward	*Patients with a learning disability are now highlighted on the daily handover sheets*
Junior doctors were not good at imparting bad news	*Human factors training was provided to junior doctors with a particular focus on communication and imparting bad news*

Conclusion

It is the responsibility of all staff to deal with any complaint or concern that is brought to their attention. If the member of staff is not able to deal with the issue then they must escalate this to their manager. Patients and their families should never be discouraged from making a complaint and information on how to make a complaint is available on the Trust's intranet.

For 2018/19 our priority again was to raise awareness of the PALS service and the help they can provide to our patients and their families. This has been successful as can be demonstrated in the increase in numbers of contacts to the service.

The Complaints and PALS team are more closely aligned with the Patient Experience team to ensure themes are shared and feedback gained to provide assurances of sustained service improvement for patients across the Trust.

Following the publication 'Hard Truths' the government's response to the Francis inquiry into the failings at Mid Staffordshire NHS Foundation Trust, the PHSO, the Local Government Ombudsman (LGO) and Healthwatch England committed to developing a user-led 'vision' of the complaints system. The vision aims to align the health and social care sector on what good looks like from the perspective of people raising concerns and complaints about health and social care. It builds on work that has previously been carried out by patient led organisations such as the Patients Association and National voices. The Care Quality Commission (CQC) will use the framework in its new inspection regime and the PHSO will integrate it into the principles of good complaint handling.

We understand that complaints are an important part of feedback and that they are a strong indicator of patient experience. We will consider how to use the framework as a definition of 'what good looks like' for our patients to measure our progress and identify actions needed to improve our complaint handling.

We share the vision that we want all people using our services to be able to say "I feel confident to speak up and making my complaint was simple". "I felt listened to and understood." "I felt that my complaint made a difference."

A user-led vision for raising concerns and complaints in health and social care
'My expectations for raising concerns and complaints' PHSO, Healthwatch England, LGO (2014)

Meeting title	**Board of Directors**	**Date: 5th September 2019**
Report title:	**Safeguarding Annual Report**	**Agenda item: 5.5**
Lead director **Report author**	**Name: Nicola Burns-Muir** **Name: Nadean Marsh**	**Title: Director of Patient Care and Chief Nurse** **Title: Head of Nursing Quality**
FoI status:		

Report summary	To receive and consider the Safeguarding Annual Report for 2018/19			
Purpose *(tick one box only)*	**Information** [x]	**Approval** [ ]	**To note** [ ]	**Decision** [ ]
Recommendation	That the Safeguarding Annual report for 2018/19 is received and noted			

Strategic objectives links	1. Patient Safety 2. Patient Experience 3. Clinical Effectiveness
Board Assurance Framework links	None
CQC regulations	
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	Safeguarding Committee, Management Board, Quality and Clinical Risk Committee
Next steps	
Appendices	

Introduction

Milton Keynes University Hospital NHS Foundation Trust (MKUHFT) recognises that Safeguarding is everybody's business and has specific responsibilities and duties in respect of safeguarding children and adults. MKUHFT is transparent in our safeguarding reporting. If a concern is conveyed to staff or by staff that an act of abuse has allegedly taken place, then a safeguarding investigation will happen immediately. A thorough investigation will be carried out involving the patient, family, carer or advocate as appropriate.

Safeguarding Children includes:

- Protecting children from ill-treatment
- Preventing Impairment of children's health and development
- Ensuring children grow up in circumstances consistent with the implementation of safe and protected care
- Taking action to enable all children to have the best outcomes in life

Working Together to Safeguard Children (2015)

Safeguarding adults indicates:

- protecting an adult's right to live in safety, free from abuse and neglect
- working together to prevent and stop the risks and experience of abuse or neglect
- promoting well-being promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action *Care Act (2014)*

This Annual Safeguarding Report provides assurance that the Trust has effective processes in place to safeguard the adults and children who access services in Milton Keynes University Hospital Foundation Trust (MKUHFT). The report reviews the safeguarding programme of work during 2018-2019, detailing local developments and activity in addition to identifying challenges and areas for improvement.

1.Safeguarding governance and assurance

The Trust's safeguarding responsibilities and compliance are guided by the statutory requirements detailed in the Working Together to Safeguard Children report (2015), the Care Act 2014 and the Care Quality Commissions regulation.

MKUHFT has a clear leadership structure with safeguarding being central to the organisation's strategic and operational work. The organisational policies referring to safeguarding are current and reflect both national legislation and local guidance. These include:

- Safeguarding Children policy
- Safeguarding Adult policy
- Mental Capacity & Deprivation of Liberty Safeguarding policy
- Chaperone Policy and Whistleblowing Policy
- Safe Recruitment, Performance Management and Disciplinary Policy

All staff working within MKUHFT have been checked on the Disclosure and Barring Service and receive annual appraisals to monitor their development and performance.

MKUHFT has a clear governance structure which includes the investigation of incidents and complaints. Incidents and complaints involving potential safeguarding concerns are dealt with in a timely manner, and where appropriate action plans formulated to improve practice and share lessons learnt. The action plans are monitored in the Trust's Safeguarding Committee. MKUHFT also strives to promote a no blame culture in order to allow staff to learn from incidences and past experiences.

The Safeguarding Committee is a sub group to the Quality Board, meeting on a quarterly basis. The committee and is chaired by the Trust's Chief Nurse and Director of Patient Care. The committee membership includes the Trust's Nursing, Midwifery and Medical Safeguarding Leads, Senior Directorate representatives and external agencies including Safeguarding Leads from the local Care Commissioning Group (CCG), Milton Keynes Council, and MKACT.

The Trust assesses itself against the safeguarding self-assessment and assurance frameworks provided to the Trust (commissioned by the Clinical Commissioning Group (CCG)) to assess, monitor and improve safeguarding on a quarterly basis, the results of which are presented and discussed at the quarterly Trust Safeguarding Committee.

The Safeguarding Committee has a planned audit schedule. During the 2018/19 financial year the team's capacity has been challenged by sickness resulting in some delays in the completion of audits.

The Trust has recently invested in a web based digital solution platform to support nursing audits. A safeguarding audit utilising this new technology will be undertaken quarterly and reported through Nursing Midwifery and Therapy's Board and Safeguarding Committee.

The audit will cover all basic elements of safeguarding across adults and paediatrics.

Safeguarding teams

The Milton Keynes University Hospital safeguarding teams work closely with all council Safeguarding Teams (across boundaries) though predominantly with Milton Keynes Council Safeguarding Team. The hospital and the council liaise regularly as to how investigations progress, other services that maybe required (multi-agency working) through to either the agreed point when risk is mitigated as much as possible or to the safe conclusion.

MKUHFT has a Named Consultant and Lead Nurse for Safeguarding Adults who work closely with the Nursing for Quality and Improvement team. This team includes specialist nurses employed to address the complex needs of vulnerable adults including the Falls prevention, Learning Disabilities, Dementia Care and Tissue Viability Nurses.

The safeguarding children's team monitors all new referrals to Children's Social Care (CSC) on a monthly basis. In line with CQC requirements the lead continues to monitor an outcome for each case.

The Lead and Named Midwife Roles have continued as merged role. The Named Midwife for Safeguarding supports all activities to ensure that the organisation meets its responsibility to safeguard and protect children and young people. There is an additional Band 6 Midwife who provides antenatal and postnatal care for clients with complex social factors such as high risk of domestic abuse, current significant substance and/or alcohol misuse and women already involved with Children's Social Care.

A Consultant Obstetrician is the Lead for Perinatal Mental Health in Maternity and works closely with the Perinatal Mental health Lead midwife. The midwife's role is to caseload women with severe and enduring mental health issues and to work with external agencies to improve perinatal mental health services.

The role of the Lead Midwife for Teenage Pregnancy is to caseload pregnant teenagers who are 17 years of age or under at pregnancy booking and work with agencies and departments to improve outcomes and services for teenage parents and their children.

The Safeguarding Team have a good working relationship with the Domestic Abuse Unit in Milton Keynes and with the Trust's resident police officer, who is be contacted for advice, support and to follow up any cases that require further information gathering or sharing under safeguarding.

The Safeguarding Leads meet monthly for peer supervision, sense check of active safeguarding's and a forum to share good practice and successes. Supervision and sense check are also continued outside of these meetings regularly for support and communication.

2.Training & Education

Successful provision of effective safeguarding clinical practices is dependent on all staff understanding their roles and responsibilities and the procedures they should follow in order to protect their patients.

Training compliance is monitored at the Trust's Safeguarding Committee and by our Learning & Development Department.

Clinical Service Units within MKUHFT who are not 90% compliant with safeguarding training are identified and senior managers are tasked with identifying why they are not meeting the locally set KPI.

All safeguarding training plans are shared at the appropriate safeguarding boards training and education sub groups and include identified learning from local and national incidents.

2.1 Safeguarding Children training

Safeguarding children training is mandatory for all staff. The level of training required depends on the staffs' level of contact with children within their roles (Table 3). Issues covered within the training include Child Sexual Exploitation, Female Genital Mutilation, Neglect and Fabricated Induced Illness.

Table 1 Safeguarding Children Training Level

Level 1	All non-clinical staff and volunteers
Level 2	All clinical staff
Level 3	All high risk areas, i.e. Emergency Department, Paediatrics and Maternity
Level 4	All Lead personnel e.g. Lead Nurse Safeguarding Children/ Executive Lead.

MKUHFT commission training from external trainers such as COMPASS and effective questioning delivered by the MASH manager. Bespoke training, following learning events, may also be included and this occurred this year following a fabricated induced illness learning event.

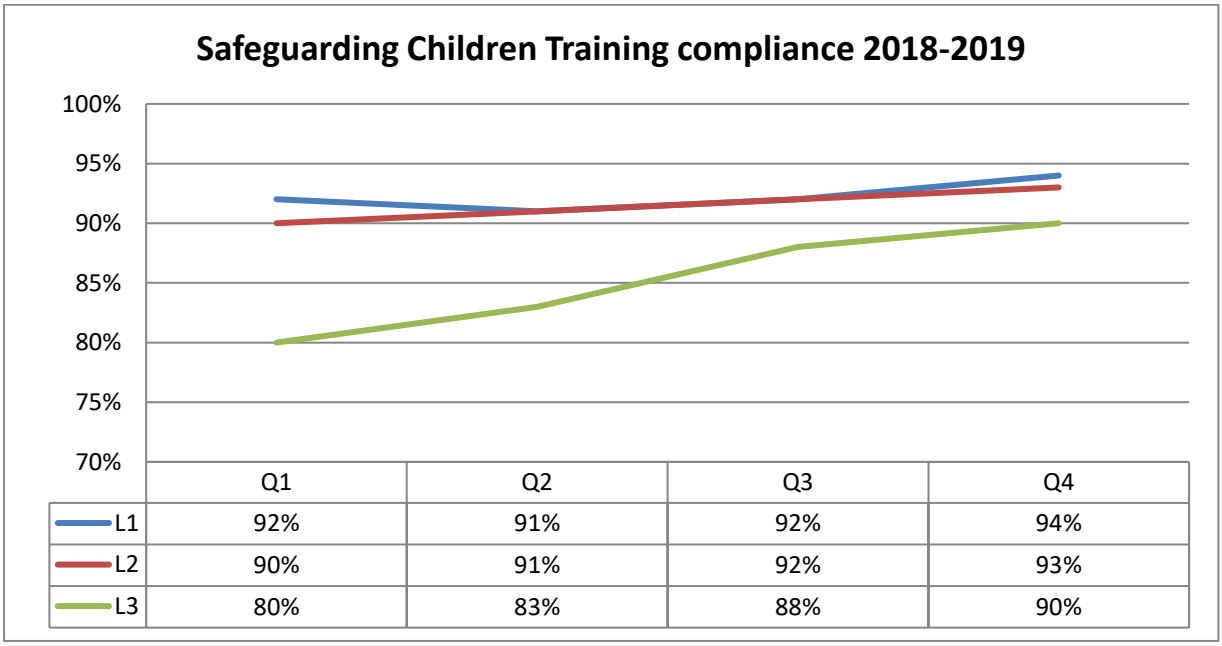
The training compliance has improved for both Level 1 and Level 2 Safeguarding Adults. The Learning and Development Department are receiving consistent positive feedback ("very interesting, informative, thought provoking), from staff attending the Safeguarding training.

Training compliance for Level 3 training (6 hours via 3 two hour sessions) remains challenging.

A review of safeguarding training for both Adults and Children in reference to the revised Intercollegiate Documents released by the Royal College of Physicians and Child Health (2018) is currently being undertaken with the focus being on providing joint training as Safeguarding Think Family. This review will also include a review of cohort of staff for whom level 3 training is most appropriate.

The graph below displays the percentage of staff compliance with safeguarding children's training in 2018/19.

Graph 1 Safeguarding Training compliance: children



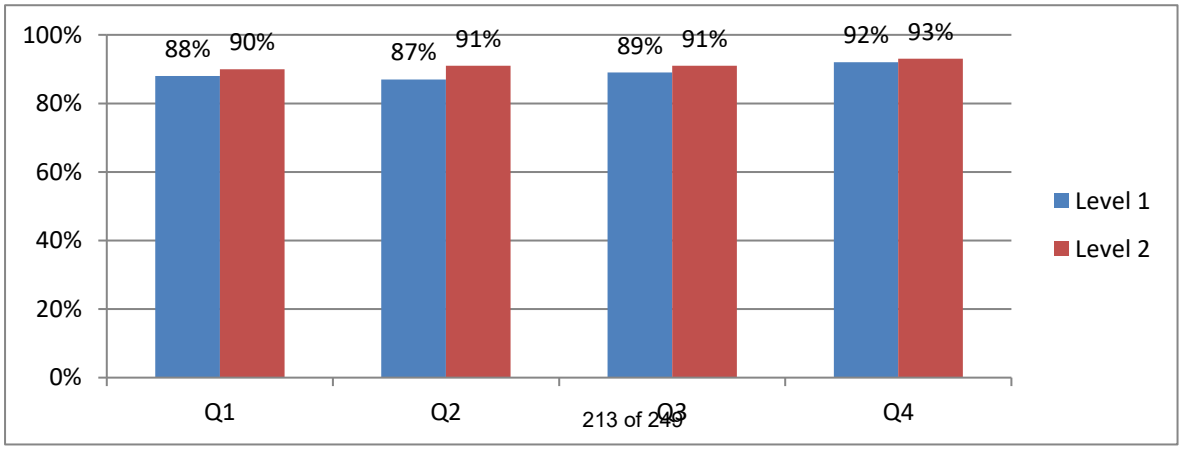
	Q1	Q2	Q3	Q4
L1	92%	91%	92%	94%
L2	90%	91%	92%	93%
L3	80%	83%	88%	90%

2.2 Safeguarding Adults training

Safeguarding Adults training is mandatory for all staff and is completed on a 3 yearly basis in a face to face classroom setting. New staff receive this training on Induction and thereafter it is available on a monthly basis, again via face to face training (to update) and bespoke training is delivered to specific departments as appropriate.

There are two levels of training, level 1 for all staff and volunteers and level 2 for clinical staff and staff with regular patient contact.

Chart 1 below demonstrates overall Safeguarding Adults training compliance for 2018/2019

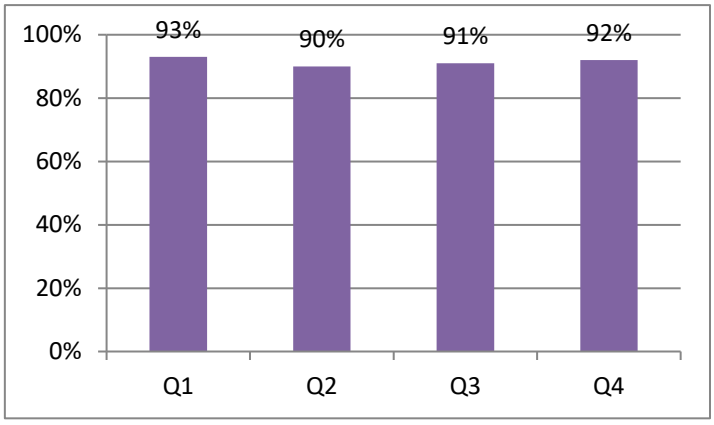


2.3 Mental Capacity Act and Deprivation of Liberty Training

Under the Mental Capacity Act, we may be required to deprive a patient of their liberty to maintain their safety, reduce risk of harm to others or administer necessary treatment when we assess them as lacking mental capacity, (decision specific. This is a serious decision and only done in the persons best interest, (in discussion and in agreement with close family, friends, professionals, advocate), and only when it is unquestionably necessary.

Mental Capacity Act and Deprivation of Liberty Safeguarding training is therefore mandatory for all clinical staff. Training is provided on a 3-yearly basis in a face to face classroom setting at induction and available on a monthly basis, with bespoke training available for specific departments as appropriate.

Chart 2 below demonstrates the training compliance for the Mental Capacity Act and Deprivation of Liberty Safeguarding training 2018 / 2019



The training compliance has continued to rise for Mental Capacity Act and Deprivation of Liberty Safeguards training. Feedback for the taught sessions is consistently positive with staff citing how clear and relatable to practice the training is. This assurance that learning is applied into practice is derived from the increased number of appropriate Deprivation of Liberty Safeguards that have been applied for over the past year.

2.4 Safeguarding Maternity Training

All midwives attend a protected week of mandatory and statutory training. The week includes sessions for:

- Child Protection and Safeguarding Level 3
- Female Genital Mutilation
- Perinatal Mental Health
- Domestic Abuse

175 staff attended sessions provided during 2018/19 which includes both trained midwives and maternity care assistants. This is slightly raised from 2017/8 when 170 staff were trained.

99% of maternity staff are compliant in receive safeguarding adults, Mental capacity assessment and Deprivation of Liberty training.

2.5 Prevent

Prevent is the United Kingdom's counter-terrorism strategy. Its aim is to safeguard individuals who are at risk of exposure to extreme ideologies and radicalisation.

Prevent awareness is included in all level 1 and level 2 safeguarding adults training. Prevent Wrap training has been delivered to all midwives.

3.Activity and Outcomes

The Safeguarding Leads for children, adults and maternity monitor the number and details of the safeguarding issues raised by MKUHFT staff.

3.1 Safeguarding Adults Activity

All Safeguarding Alerts, raised either by external services or by MKUHFT, go via the appropriate local council's safeguarding team. This team will appoint an external safeguarding officer if required for investigation. The council will liaise with the hospital until they are satisfied that the investigation is closed and sufficient action to mitigate risk to the person at the centre of the concern is complete.

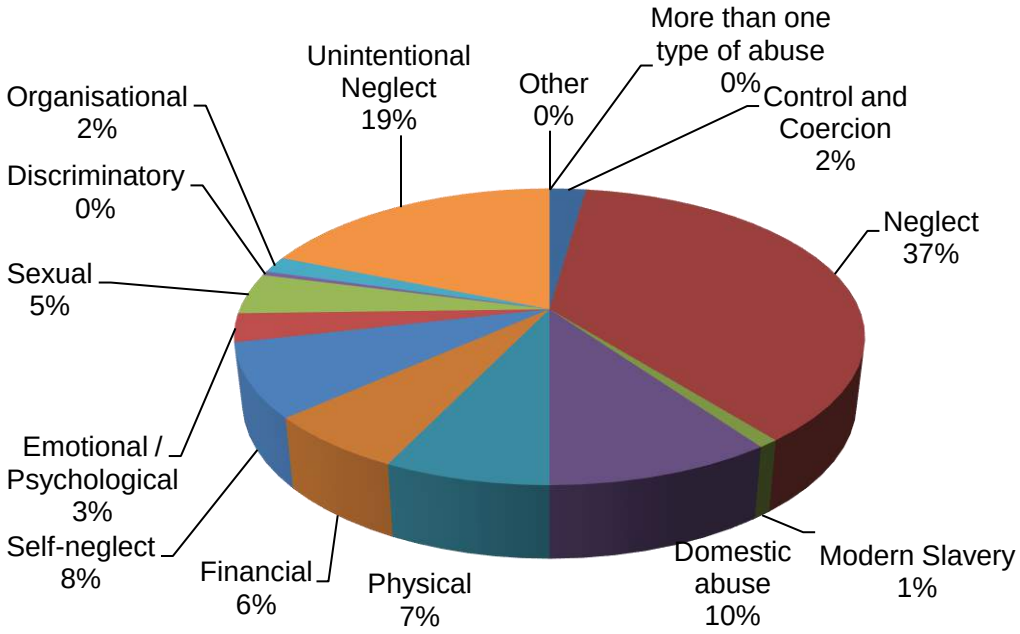
Safeguarding alert numbers are reported and discussed at the Trust Safeguarding Committee and any serious safeguarding alerts are immediately discussed with the Care Commissioning Group (CCG) Safeguarding Adults Lead. The Trust has a transparent policy on adult safeguarding alerts and will report on the electronic incident reporting system (Datix) to ensure that the Risk Governance team have oversight of any investigation. On occasion the council will be advised by the adult safeguarding lead to redirect the concern through to MKUHFT Patient liaison and Complaints Team, if deemed to provide a more suitable outcome for those affected. Through the above processes the incident will be reviewed by a senior executive and if agreed, a serious incident will be declared, and a separate investigation will be overseen by the CCG.

In 2018/19 MKUH raised **224** Adult safeguarding alerts. There has been a 5% decrease (13 alerts) in adult safeguarding alerts raised in 2018/19 compared to 2017/18/. Staff report that they continue to feel confident in their knowledge of how to access the safeguarding team, to discuss concerns and increasingly confident in how to complete a safeguarding alert.

There has been a wider variety of professions and departments contacting safeguarding adults to discuss concerns in 2018/19 in both inpatient and outpatient services. This continuation of appropriate alerts from a breadth of professions provides assurance of success in the Trust's training programme.

Chart 3 identifies the breakdown of alerts by theme.

Chart 3 Safeguarding Alerts by theme



The table below identifies the adult safeguarding alerts raised by theme and location of alert.

Table 2 Adult Safeguarding alerts 2018/19

Category	MKUH vs MKUH	MKUH vs External agency	External agency vs MKUH	External agency vs External agency	Total 2018/ 2019
Control and Coercion		5			**5**
Neglect	1	50	13	19	**83**
Modern Slavery		2			**2**
Domestic abuse		22			**22**
Physical	1	10	1	4	**16**
Financial		11		3	**14**
Self-neglect		11		6	**17**
Emotional / Psychological		7			**7**
Sexual		7		3	**10**
Discriminatory		1			**1**
Organisational		4	1		**5**
Unintentional Neglect		29		**13**	**42**
Total	**2**	**159**	**15**	**48**	**224**

Neglect and unintentional neglect are commonly the largest reported categories as they encompass a variety of concerns including pressure ulcers, poor mouth care, alleged new skin condition, and unintentional neglect given by family/carer. In 2018-2019 self-neglect was identified as a key focus of investigation for the Milton Keynes Adult Programme Board.

Domestic Abuse are 10% of alerts which is slightly lower than the previous year (13%) with MKUHFT raising all 22 safeguarding alerts. Staff have improved on actively discussing suspected domestic abuse with patients and raising their concerns to the safeguarding lead, who will then progress if appropriate. It is difficult to identify if this is a reflection of successful training or whether the victims or families/friends have felt more supported to ask for help. There have been 5 Control and Coercion and 2 Modern Slavery alerts in 2018/19 both of which are serious crimes and a focus of the Milton Keynes safeguarding board therefore positive that staff have successfully raised alerts.

3.1.1. Alerts Raised by MKUHFT against MKUHFT

2 alerts have been raised by MKUHFT against MKUHFT in 2018/19. This number indicates a continued decrease from 3 raised in 2017/18 and 19 in 2016-2017.

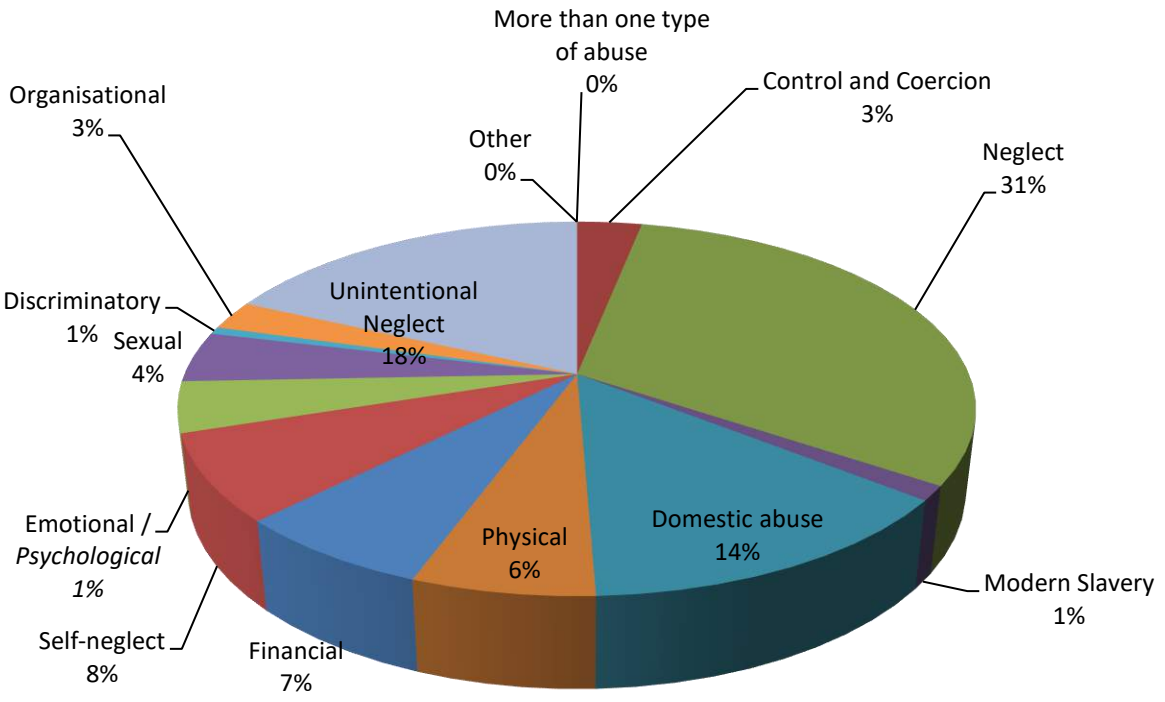
Alert 1 was a neglect alert relating to the poor discharge of a patient who attended the Emergency Department following a fall sustaining a fractured ankle. A plaster of Paris cast was applied, and information was given to the patient to be non-weight bearing. Consideration was not given as to how the patient was going to cope in the community nor was a walking assessment undertaken or aid given. This incident was investigated through the Trusts datix reporting system.

Alert 2 was a physical alert relating to a patient alleging a staff member had pinched them causing a skin tear. This was investigated under the section 42 process. Due to inaccuracies in the patient's statement the staff member was unable to be identified.

3.1.2 Alerts Raised by MKUHFT against external parties

Each year we are see a consistent number of safeguarding alerts raised by MKUHFT against external parties. It is reassuring that staff identify and know how to escalate these concerns with due process. Chart 4 shows a breakdown of the alerts made regarding external sources by MKUHFT staff.

Chart 4 Safeguarding Alerts made by MKUH against external agencies by Category 2018-2019



In 2018/19 there has been an increase in referrals raised against external agencies for neglect. The majority of these relate to patients being admitted to hospital with a moderate level of pressure damage or injury from either a care home or the patient's own home where a care agency has been providing support.

3.1.3 Alerts Raised by External parties against MKUHFT

MKUHFT received 15 safeguarding alerts raised by external parties in 2018/19 which are investigated by the Trust. This is a reduction compared to the 52 alerts raised against MKUHFT in 2018/19. The breakdown of allegations is tabled below.

Table 3 Safeguarding Alerts made by external agencies against MKUHFT by Category 2018-2019

Theme	**2018/19**	**2017/18**
Neglect	93%	67%
More than one type of abuse	0	4%
Other	0	0
Unintentional neglect	0	25%
Physical	7%	4%
Emotional/ Psychological	0	0
Financial	0	0

The majority of alerts are raised as neglect and these mainly refer to pressure damage deemed to have occurred during admission and discharge from the Trust. Examples of the discharge allegations made are:

- Patient being discharged home and no care package organised
- Patient being discharged home and District Nursing team unaware of requirement to visit

Following investigation, the main themes from these alerts are

- a breakdown in communication when planning discharge and
- Pressure ulcers that we had already raised as hospital acquired.

The safeguarding Adult lead will continue to work closely with the Trust Discharge Lead to review safeguarding alerts related to discharge and will also liaise with the CCG to provide assurance. Section 42 safeguarding alerts are now allocated to the Trust more robustly for investigation and a high proportion of the alerts relating to neglect (mainly pressure damage) are now being screened through this investigative route.

There was one alert raised pertaining to physical abuse. This relates to a concern raised by a care home that a discharged patient had a bite mark on their shoulder. This was investigated and found to be un-substantiated.

There were no serious alerts raised by external that required external investigator or police involvement.

The Trust has not made any referrals to Prevent in 2018/2019.

Not all safeguarding alerts raised against MKUHFT reach the threshold of adult safeguarding; these that do not are predominantly complaints or concerns. These concerns, if substantiated, continue to be investigated as lessons learnt.

The Milton Keynes Quality Sub Group have discussed the number of inappropriate alerts that have been received across the area and the group have concluded that further learning needs to occur on appropriate safeguarding reporting. This includes guidance as to when to contact the ward/hospital directly to discuss an omission or a complaint. The safeguarding lead will continue to feedback to the supervisory body of inappropriate alerts but also to redirect through to complaints if more appropriate.

3.2 Safeguarding Children Activity

The safeguarding children's team monitor all new referrals to Children's Social Care (CSC) on a monthly basis. In line with CQC requirements the lead continues to monitor an outcome for each case.

The safeguarding children's team maintain a database of contacts and this shows that the number of contacts with the service remains constant over the past year. The numbers do not reflect the increasingly complexing of cases that are being dealt with daily by the team as nursing staff become more competent and confident in addressing basic safeguarding concerns.

The Multi Agency Safeguarding Hub (MASH) is a collection of professionals including Social Workers, Health staff and Police who work together to review and agree actions following concerns referred to them. Most of the referrals made by MKUHFT are taken up by CSC and acted upon some requiring a section 47 investigation or Section 17 Child in Need Plan set up. Some are sent on to Early Support and taken up by Child and Family Practice workers who work with these vulnerable families to support them and provide them with basic life skills. A breakdown of the referrals made by the hospital can be seen in the table 5, for 2018/19.

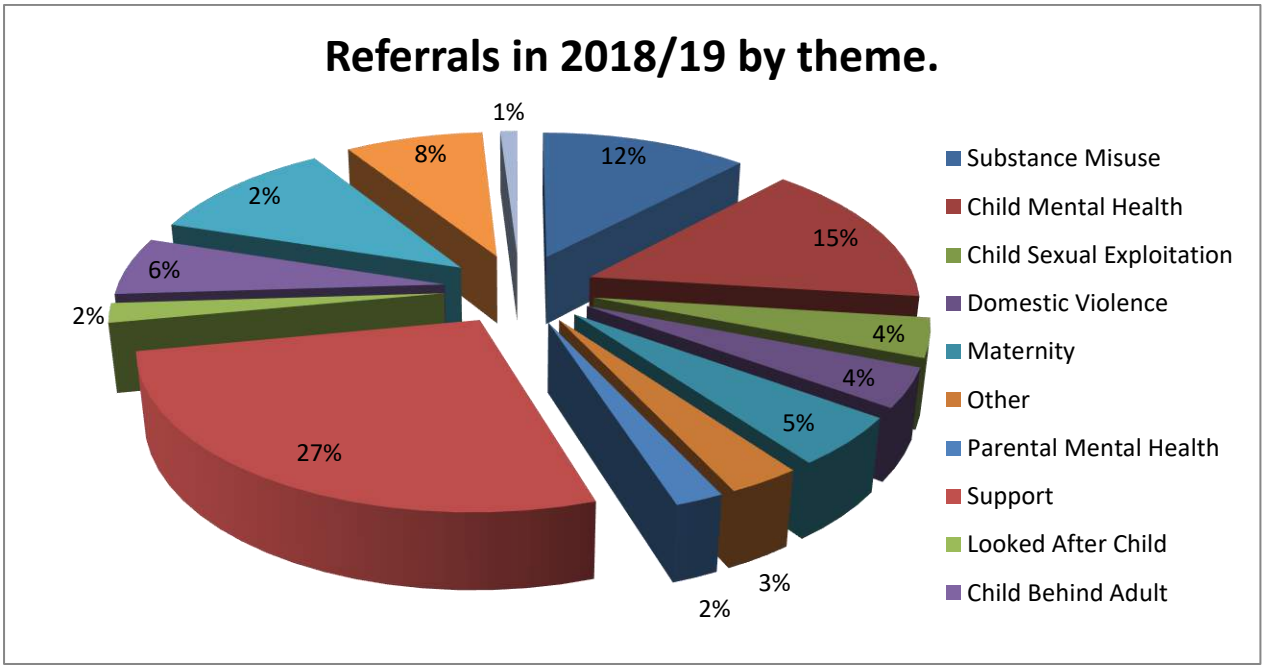
Table 4 Referrals and Outcomes by month 2018/19

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
Number of referrals taken up by MASH	48	47	20	23	24	29	29	43	37	34	39	51	424
Number of referrals sent to CFP.	8	11	3	3	1	1	3	7	5	6	11	5	64
Number of Referrals actioned by MASH with no further action taken.	27	17	4	7	16	11	4	19	17	10	15	10	157
Number of referrals closed with no action taken	13	3	5	4	1	5	2	1	3	1	3	9	50
Number of referrals open to children's social care	9	9	8	10	5	13	17	17	13	17	10	25	153
Child Protection Medicals													32

The number of safeguarding referrals has decreased since last year by a third and the number of referrals that were closed with no action taken has reduced from 136 in 2017-2018 to only 50 in 2018/19. The team feel that this provides assurance of the appropriateness and standards of referrals.

Using the data from the referrals made we can categorise the principle theme for the referral, seen in Chart 3 below

Chart 5 Referrals by Theme



The data demonstrates the complexity of cases that are being referred, with 153 of the referrals being opened to children's social care. Themes for these referrals include child mental health referrals (just under a fifth of the total number), substance misuse, looked after children and child on protection plan.

In 2018/19 MKUHFT completed 32 Child Protection Medicals, a decrease from 46 in 2017/18. These medicals take place in the acute ward areas and due to capacity, children often must wait until emergency patients are reviewed and treated before they are seen, which can add to the distress and anxiety of the difficult situation. These concerns continue to be shared with the CCG with discussions ongoing regarding the most appropriate place for these to be completed. We now have a Paediatrician working with both MKUHFT and CCG to review this pathway.

3.2.1 Child Deaths

The Named Doctor sits on the local Child Death Overview Panel (CDOP). The Trust has a Communicating the Death of a Child Policy that is available to all staff and should be followed in all deaths up to the age of 18 years.

Table 5 Number of child deaths reported in Milton Keynes by Month 2018/19

Month	Number of child deaths recorded
April	1
May	1
June	2
July	4
August	1
September	1
October	1
November	0
December	5
January	0
February	4
March	0
Total for year	20

3.3 Lead Midwife Vulnerable Families & Named Midwife Safeguarding Activity

60 referrals where made to the Lead Midwife for Vulnerable Families during 2018/19. These referrals often have a multiple complex social history as tabled below:

Table 6: Safeguarding midwifery referrals

Children's Social Care (CSC) involvement	19
Domestic Abuse	11
Domestic Abuse with (CSC) involvement	9
Domestic Abuse and Mental Health	1
Honour Based Violence	1
CSC and Mental Health	3
Substance Misuse	7
Substance Misuse and Domestic Abuse	3
Under Witness Protection	1
Non Engagement with Midwife	1
Adoption	1
Concealed Pregnancy	1
Concerns over parenting	1
Previous Child Removed	1

Public Law Outline was required for 30 babies of which 13 babies were discharged into the care of the local authority/Family Member, 4 to a joint placement and 4 went home with their mother, from the Maternity Unit. A further 7 babies were on a Child Protection Plan and 19 Child in Need.

Additional activity to support maternity services:

- The Children's Social Care Maternity plans are now in circulation and provide more robust information from Maternity and the Trust in terms of expectations and risks for the newborn
- The 'Best Practice' for when babies are placed in the care of a family member or the local authority to help support the family and staff in this difficult time. This is now included as part of the Postnatal care Guideline to support staff in caring for these families.
- Support has been provided to families involved in the Foster to Adopt process though the St Frances' Children's Society to help understand care that takes place in for in pregnancy and for a newborn if a mother experiences a Substance Misuse issue.

3.4 Perinatal Mental Health Activity

In 2018 – 2019 the Perinatal Mental Health lead midwife's caseload was 55 women with severe and enduring mental health issues. This comprised of women with Bipolar, schizophrenia, severe depression and acute anxiety (OCD) and women with complex trauma and personality disorder.

Many of the women have highly complex social issues and high risk obstetric factors therefore working with other services is essential. One of the families worked with Children and Family Practices, 13 were open to Children's Social care and 7 babies were placed in foster care at/following birth. The Lead Midwife for Perinatal Mental Health attends all Core Group meetings, Family Support Meetings, Strategy Meetings and Child Protection Conferences and Review Child Protection Conferences in relation to women on her caseload.

Table 7: Incidences of mental health disorders on caseload 2018-2019

Mental Health Disorder	Number of Women
Personality disorder	21
Bipolar	4
Previous traumatic abuse – PTSD	5
Previous postnatal depression	4
Anxiety/Depression	22
Schizophrenia	2
Previous psychosis/postnatal psychosis	3
Severe OCD	2
Eating disorder	1

The Consultant Obstetrician, lead midwife for Perinatal MH and the Perinatal MH team Manager and Consultant Psychiatrist are planning to develop Joint Perinatal Mental Health and Obstetric Clinics. The implementation of these joint clinics is one of the key plans identified by the BLMK Local Maternity System project group as part of the implementation of the Better Births Plan across the STP.

3.5 Lead Midwife Teenage Pregnancy Activity

Milton Keynes demonstrates a falling long-term trend for under 18 conception rates that continues into 2017, though Milton Keynes remains statistically similar to the national teenage pregnancy rate.

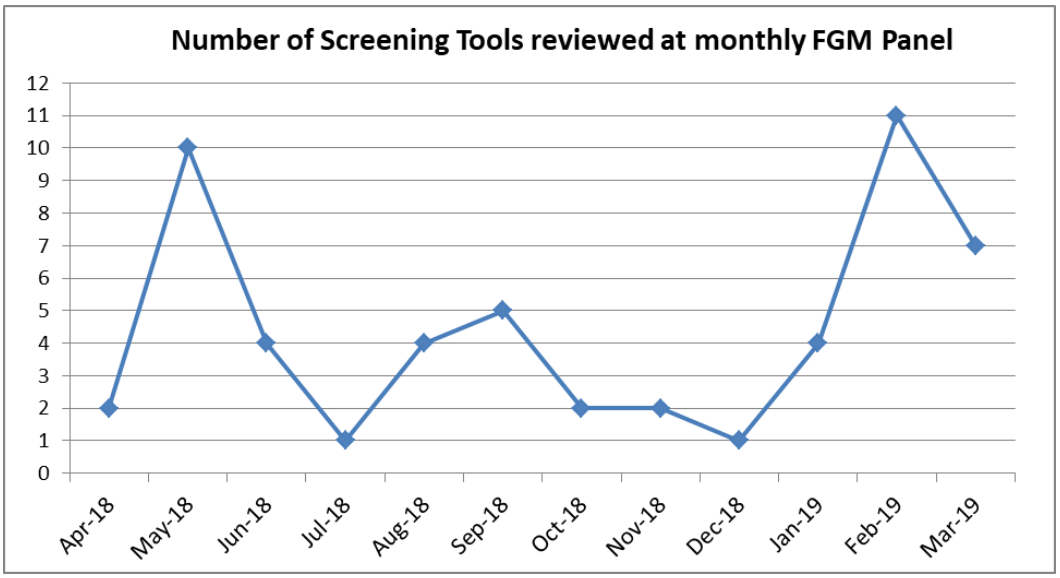
In 2018/19 the Lead Midwife for Teenage Pregnancy held a case Load of 31 Clients. All pregnancy booking, as well as routine antenatal and postnatal care was completed at home. Of these 31 clients, 16 had previous or current mental illness. 20 had current or previous involvement with:

- Children Social Care (CSC)
- Children and Family Practices (CFP)
- Other Social Concerns included Substance abuse, Smoking, Domestic abuse,
- Crime and housing issues.

3.6 Female Genital Mutilation (FGM) Activity

Mandatory reporting of FGM by health professionals continues with the majority of the 51 reports (68%) referred from maternity and 11% from sexual health services. 50% of referrals are women of Somalian origin. In 2018/19 an FGM- Information Sharing (FGM-IS) Indicator has been introduced. This means that all female infants born to a mother who has undergone FGM has an indictor placed on their NHS Summary care records. MKUHFT are currently finalising the ability for this information to be extracted to eCare alongside the Child protection – information Sharing Indicator (CP-IS).

The following data looks at the FGM Screen tools received by the FGM panel for 2017/18.



Confidential Communiques Update

The use of an electronic Confidential Communique to identifying those women and unborn babies that may have complex social needs continues to be used in order to communicate within Maternity Services and notify the Health Visitors. Since the implementation of e-Care within maternity services the process remains the same where the Lead Midwives for Safeguarding, Teenage Pregnancies and Perinatal Health are required to collect the printed copies from the Maternity clinical areas which are then scanned and emailed to the Health Visiting Team.

The Confidential Communique is currently logged on the Risk Register as its effectiveness is not as robust as previous. A recent review of this process was undertaken to ensure safeguarding practice is robust and provides assurances and some additional actions have been put in place to ensure staff are following the process. It has not been possible to use this tool to pull data as has been the case in previous years and so the audit criteria have been reviewed.

3.7 Mental Capacity Act and Deprivation of Liberty Activity

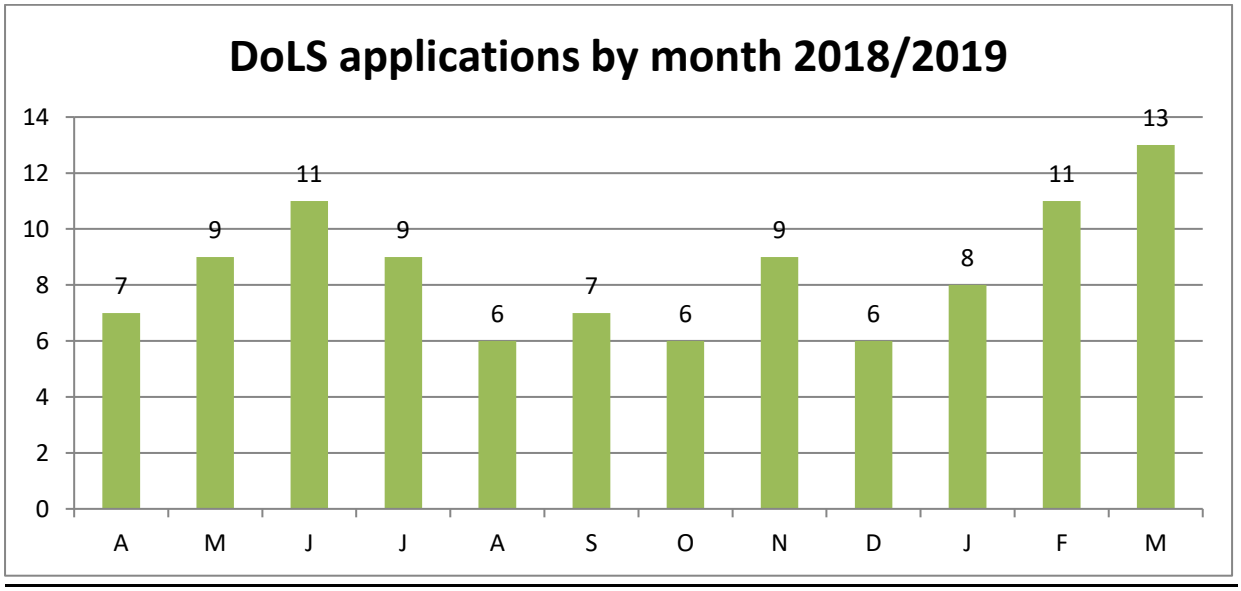
In 2018/19 the Trust has seen a slight decrease in the number of Deprivation of Liberty Safeguarding's requested. 102 applications were made which 13 referrals less than 2017/18. Deprivations of Liberty Safeguards (DoLS) are reported to the Safeguarding Adults Lead Nurse or the Clinical Site Manager to be approved and signed prior to being sent to the Supervisory Body, (the appropriate council where the patient is a resident or the council that is funding the care in the community).

The Adult Safeguarding Lead and the wards work closely with the councils DoLS teams in reviewing each DoLS to stay within the legal limitations of the Mental Capacity Act and legislative timescales that this involves. The safeguarding adults lead liaises regularly with the councils to review current practice and review of practice that may require addressing.

The Safeguarding Adults Lead attends the Milton Keynes Safeguarding Adults Board MCA & DoLS sub-group meeting where Milton Keynes DoLS are discussed.

Chart 7 shows the monthly applications made to the supervisory body by MKUHFT relating to DoLS.

Chart 6: DOLS applications by month



3.8 Dementia activity

The Dementia Team continue to promote awareness across the Trust in recognising symptoms of dementia and promotion of management strategies. Training is delivered through essential skills programme using a multi-professional approach.

An electronic Dementia Awareness workbook has been designed and is being promoted via the Safeguarding and Quality Intranet page for all non-clinical staff to access.

The Trust has implemented Johns Campaign which provides a framework for staff to enable relatives and carers to remain with a patient outside of the routine visiting hours. This encourages communication between professional and carer enabling the provision of compassionate, supportive care. The campaign has been adopted for patients with learning disabilities, mental health diagnosis of anxiety, depression as well as a dementia diagnosis

Communication resource boxes are now in all clinical areas/outpatient departments. These boxes contain both practical and social items such as hearing aid batteries, magnifying glass, colouring sheets, reminiscence folders and twiddle muffs. Enhanced observers are encouraged to use these boxes to engage with the patients they are caring as a tool to aid stimulate conversation and engagement as well as distraction therapy. An audit of these boxes within the clinical areas and with patient engagement group is planned for next year to ensure the correct activities/items are being provided.

MKUHFT continues to host their own Dementia Café once a month where on average 5-6 patients attend. The café has been operating for a year now and continues to provide a relaxed friendly atmosphere for patients, relatives, carers to enjoy conversation, exchange ideas and offer support to each other. The Dementia team are also in attendance to provide any support, information or signposting and are looking at the option of pop up cafes within clinical areas.

To promote a positive dining experience dining tables have been placed within clinical areas to encourage patients to move from their bed side, socialise, sit together to eat meals. This is supported by staff within the organisation that provide time within the day to be dining campanions.This is also in line with the Trusts promotion of the national initiative of 'end PJ paralysis'.

Learning from a patient and relative's story was shared at Trust Board and other staff forums. Due to the success of this, and with permission of the relative, a video of this experience was made and has been integrated into Dementia training.

MKUHFT staff have contributed to the development of an Open University Dementia course that will commence in October 2018 for a cohort of 25 staff.

3.9 Learning Disability activity

People with learning disabilities can find it challenging to come into hospital for multiple many reasons. At MKUHFT we continue to develop strategies to support and overcome these challenges. The Vulnerable Adults Nurse takes the lead on supporting these patients and their families and will routinely visit the patients and families when on the ward and to support the staff with any concerns they may have. They also enhance effective communication between patients and their families and staff and support discharge, by signposting extra help in the community if required.

Last year we implemented the National Learning and Disability Mortality Review Programme (LeDeR). The LeDeR reviews all deaths to improve care for patients who have a Learning Disability. They work to make sure that any factors that are modifiable will not be repeated to improve the care that our patients have when they enter hospital. Within the Safeguarding committee learning from incidents, have been shared and a lower threshold for investigation has been agreed for complaints, concerns, and incidents involving people with learning disabilities.

One positive example of this was a 'not brought to appointment' case. A young person with a learning disability was highlighted as not attending hospital appointments. Time was spent communicating with the young person's mother to understand the challenges, reasons why appointments were missed. A full multi-disciplinary approach was adopted to provide the required care to the young person during a lengthened appointment.

A pathway for persons with complex needs is now being developed to capitalise on this work.

4. Learning from Serious Case Reviews, Safeguarding Adult Reviews and Serious Incidents.

As a member of the local Safeguarding Boards the Trust may be asked to participate in single agency reviews or multi agency in-depth reviews of individual cases. Occasionally the decision is made to undertake a Serious Case Review, when it involves a child, or Safeguarding Adult Review, when it involves and adult. All agencies involved in the care of the individual may be asked to share and learn from a case where it has been agreed that learning and action is required to prevent or limit similar circumstances arising again.

Serious Case Review

MKUHFT has been involved in 1 Serious Case Review. This related to antenatal pathways and the outcome of the review is currently pending publication.

Learning Reviews: MKUHFT has been involved in contributing to two local learning reviews both pertaining to non-accidental injuries. Recommendations are still to be published.

Safeguarding Adult Review

MKUHFT has been involved in one SAR related to a regular attender at hospital community and police services. The final publication is due June 2019.

Serious Incident

One reported Serious Incident for Safeguarding children was declared in November 2018. Children's services have now developed an action plan in relation to the incident, which was agreed by the CCG.

It is noted that there were 12 pressure ulcers which were reported as serious incidents, which this report does not detail due to other reporting mechanisms to Board.

5. CCG Safeguarding Assurance Framework

The annual children's and adults safeguarding assurance audit was untaken by the CCG in June 2019.

5.1 Safeguarding Children's Assurance Framework including Section 11 Audit

This tool is an assurance framework to support organisations to audit activity and identify areas of improvement regarding safeguarding and promoting the welfare of children. The assurance framework is benched marked against a scoring process.

Table 8: Safeguarding Children Assurance Framework

Rag Rating	2016	2017	2018	2019
Blue – excelling	1%	1%	3%	10.5%
Green- effective and consistent	82%	83%	87%	84.2%
Amber/ Green – meets most of the requirements	14%	16%	6%	0
Amber – met in part, improvement needed	3%	0	3%	5.3%
Red / Amber – met in part, significant improvement needed	0	0	0	0
Red – not met	0	0	0	0

Following a review of the Section 11 Assurance Framework with the CCG assurance was given that good practice was being met and noted positive examples of continuous improvement. There was also acknowledgement that despite capacity being limited due to long term sick leave the operational functioning of the safeguarding team had not been impacted.

The main recommendations for consideration following this review are for MKUHFT:

- to improve training compliance, particularly level 3
- to review deliverance of safeguarding training in line with the revised Intercollegiate Document 2018
- to approve Safeguarding Supervision Policy
- to review any complaints that have a safeguarding element to them and share learning themes.
- to undertake quarterly Safeguarding audit using Perfect Ward Application.
- to provide assurance of locum staff receiving information on local process of how to raise concerns

5.2 Safeguarding Adults Assurance Framework (SAAF)

This audit tool supports organisations with their regard to the need to safeguard and promote the welfare of adults. The self-assessment framework examines six different sections, within these are 34 subcategories safeguarding adults is rag rated against.

A. Leadership, Strategy, Governance

B. Workforce, organisation culture & Learning

C. Organisations approach to workforce issues reflect a commitment to safeguarding & promoting the wellbeing of adults at risk

D. Effective multi-agency working to safeguard and promote the wellbeing of adults at risk

E. Mental Capacity Act & Deprivation of Liberty Safeguards

F. The service can demonstrate that people who use services are informed about safeguarding adults & empowered within the organisation's responses to it.

Following a review with the CCG at the end of the financial year the panel were pleased to be assured of the continued improvements in the service. The table below demonstrates the improvements in the rag rating from April 2015 to March 2017

Table 9: Safeguarding Adults Assurance Framework

Rag Rating	March 2015	March 2016	March 2017	April 2018	June 2019
Blue – excelling	0	0	0	6 (18%)	9 26%
Green- effective and consistent	13	20	25	22 (65%)	20 59%
Brown – meets most of the requirements	13	12	9	6 (18%)	5 15%
Amber – met in part, improvement needed	8	2	0	0	0
Pink	0	0	0	0	0
Red – not met	0	0	0	0	0

Overall it was agreed that MKUHFT had continued to sustain robust arrangements for safeguarding adults. Reference was made to areas of good practice and how the safeguarding team, are continually looking for ways to strengthen MKUHFT safeguarding work. It was noted there was evidence of strong leadership and robust governance through the MKUHFT safeguarding committee demonstrating good integration across all services.

Since the last assurance meeting a new safeguarding lead has been appointed. There are two specialist safeguarding nurses working across both adults and children's safeguarding providing support to frontline practitioners.

A safeguarding hub has been developed within the organisation to facilitate collaborative working across all disciplines and promote Safeguarding -Think Family.

The following recommendations and actions have been developed following this review for MKUHFT and the safeguarding CCG:

- to identify practitioners who would support undertaking safeguarding section 42 enquiries
- to safeguarding supervision policy MKUHFT to undertake a safeguarding audit to review if making safeguarding personal is captured through documentation
- to undertake quarterly safeguarding audit using Perfect War Application
- to provide assurance of locum staff receiving information on local process of how to raise concerns

6. Future Developments for 2019/20

We will continue to ensure all safeguarding training compliance meet Trust targets throughout the year . We will remain engaged with multi agency partners to improve communication and the quality of care and experience of our patients and develop robust safeguarding databases with EPR systems.

We aim to develop a collaborative approach to children's and adults training in order to encourage staff to think of 'safeguarding the family' and not singularly the adult or the child.

6.1 Adults

The Vulnerable Adults Nurse will be providing more bespoke Learning Disability Awareness training in MKUHFT and will look at supporting children with a learning disability transition into adult services within MKUHFT.

With the introduction of eCare in May 2018 we will look to review the assessment of pain in patients with dementia, with a review of The Abbey Pain assessment tool in collaboration with the Pain team.

We will continue to promote Johns campaign within the Trust and review the effectiveness and experience for families and carers.

Within the Dementia clinical service unit we are developing a Dementia strategy for the Trust, incorporating the vision that: "Every patient with a diagnosed dementia admitted to MKUHFT is recognised, treated with respect and dignity by all staff who demonstrate awareness, understanding, and the skill appropriate to their own role and involvement with that person who has dementia including their relative or carer".

To review DHSC Pressure Ulcers 2018 Safeguarding Adult Protocols in collaboration with CCG to agree an implementation strategy

6.2 Children

The welfare of adolescents in the Trusts remains a priority and the safeguarding team attends the Trusts daily safety huddle where information is shared where any 16 to 18 year olds are in the Trust to prioritise any additional support that may be required to ensure the young person's welfare is protected.

There has been considerable work undertaken between MKUHFT and Oakhill secure training centre to agree a memorandum of understanding. This was implemented in both agencies during October 2018. A review of the effectiveness of the document will be prioritised for 2019.

We plan to review the pathways for children requiring Child Protection Medicals ensuring they occur at the right time in the right place to the right child.

We will continue to embed Female Genital Mutilation, Children Sexual Exploitation and Neglect, fabricated induced illness Toolkits across MKUHFT.

6.3 Maternity

The Common Assessment Framework (CAF) document is in the process of being ratified and once approved support for Community Midwives will be put in place in using the document.

With the changes to Continuity of Carer from the Better Births Implementation plan, more availability to support the Trust with Safeguarding in Maternity. This shall include:

- Monthly Workshops on a variety of Safeguarding topics
- Care planning alongside the Midwives for those Families who do not reach the threshold for the Vulnerable team but have Complex social Needs
- Increase availability for Safeguarding supervision
- More availability for contact with Trust to support with current Safeguarding concerns

Introduce annual Safeguarding Drills around the Abduction Policy

We will liaise with the Local Authority to improve support for women who have had a baby removed including emotional wellbeing support.

Audits planned for 2019/20

- Safeguarding knowledge (Children and adults)
- Serious case reviews, lessons learnt
- Attendance of adolescents from Oakhill Secure Training Centre
- Review of Safeguarding adults' referrals, looking at the use of making safeguarding personal
- Review of Multi Agency Referral Form, looking at the use of signs of safety

Milton Keynes University Hospital NHS Foundation Trust

Meeting title	Board of Directors	Date: 5 September 2019
Report title:	Report of the Management Board meeting held on 9 August 2019	Agenda item: 5.6
Report author	Name: Joe Harrison	Title: Chief Executive
FoI status:	Public document	

Report summary				
Purpose *(tick one box only)*	Information [x]	Approval [ ]	To note [ ]	Decision [ ]
Recommendation	The Board is asked to note the update from the Chief Executive summarising the outcome of discussions at the August Management Board meeting.			

Strategic objectives links	All
Board Assurance Framework links	None
CQC regulations	None
Identified risks and risk management actions	None
Resource implications	None
Legal implications including equality and diversity assessment	None

Report history	
Next steps	
Appendices	None

Chief Executive's Report - key points arising from the Management Board meeting on 5 August 2019

1. **Chief Executive update**
   - In advance of the new staff car parking arrangements going live on 1 September, Management Board members were asked to remind their staff to register onto the new provider's systems by the end of the month.
   - It has been confirmed that Luton & Dunstable FT's £99.5m capital bid has been approved, thus enabling the planned acquisition of Bedford Hospital to proceed.

2. **Quarter 1 Complaints and PALS report**

   - Management Board noted the rise in the number of complaints in the Surgery and Women's and Children's Divisions. Staff manner and attitude, and communication with patients and their families remain two of the most common themes.
   - The work that has been done in Surgery and Medicine to seek to resolve as many issues as possible on the same day that they were raised was commended, and it was confirmed that the other 2 divisions will seek to replicate this initiative in ways that are suitable to their teams.

3. **Infection Prevention and Control Annual Report 2018/19**

Management Board received the Infection Prevention and Control Annual Report for 2018/19. The following points were raised in the course of its discussion:

   - The Trust has treated some very unwell patients who have highly resistant infections. This poses immediate management challenges which potentially impacts on the environment and other patients.
   - The infection control team is small but skilled, and it works well with others. The team's establishment was recently increased, meaning that they are able to conduct more visits. It was agreed that a member of Management Board would accompany them on their visits to reinforce the importance of this issue.
   - The in-house hotel services team is one of the Trust's biggest assets in keeping people safe.
   - The Trust has only a few single rooms and these must be used to the best advantage.
   - The CQC's comments on hand hygiene as observed during their visit have been taken on board. Further work is being done with the Emergency Department, and alcohol-free hand sanitisers are now available. Messages around being "bare below the elbow" are also being reinforced
   - The Trust performs well in relation to C-difficile, but challenges remain around anti-microbials. Around 75% of e-coli cases continue to originate from community settings.

4. **Estates**

- The ward 16 entrance is to be closed to vehicles with effect from 29 August and reopening on 6 November, in order that the resurfacing work can be done to the fire road. There is a plan in place for alternative vehicle movements during this period, and the signage in that area will be altered to reflect this.
- The Cancer Centre project remains on time and on track.

5. Other Business

- The Director of Workforce has put a system in place to help ensure that appraisals are conducted on time. It is important that this process is used as a way of helping staff to feel valued and engaged.
- The Deputy Chief Nurse highlighted examples of good pan-organisational work that has been done in response to some difficult safeguarding issues and commended all those involved.

Milton Keynes University Hospital NHS Foundation Trust

MEETINGS OF THE FINANCE AND INVESTMENT COMMITTEE HELD ON 1 July and 5 August 2019

REPORT TO THE BOARD OF DIRECTORS

Matters approved by the Committee:

There were no matters that were approved by the Committee.

Matters referred to the Board for final approval:

No matters were referred to the Board for final approval.

Matters considered at the meetings:

1. Performance dashboard M2 and M3

At the July meeting, the increase in GP referrals to Ophthalmology was noted – the reasons behind this are being analysed by the CCG. Efforts to reduce "Did Not Attend" rates in the Trust are being intensified, although it remains the case that MKUH's rates are in line with national averages.

At the August meeting, it was reported that while A&E performance remains good, performance against the 18-week RTT standard requires attention. It was acknowledged that the Trust needs to maintain its focus on managing waiting lists, and there was confirmation that one patient has been awaiting elective treatment for more than 52 weeks. Regarding the relatively high number of staff vacancies, it was noted that this is largely a timing issue and should be addressed when the next cohort of graduating nurses arrive at the Trust later in the year.

2. Board Assurance Framework:

At the July meeting, the Committee decided to increase the rating of BAF risk 7-2 (capital expenditure) from 5x3=15 to 5x4=20 based on the national approach that was at that time being taken on the provision of capital funding. Cognisance was taken of the constraints that the Trust was under considering that it had already made several contractual commitments. However, by the time of the August meeting, it was reported that there is now more certainty in the system, following announcements that had been made about the capital funding, including for Luton and Dunstable Hospital. On this basis, it was agreed that the rating would be reduced to 4x4=16.

There was acknowledgement of changes in the external environment with more powers being to the ICS, but the Trust is maintaining good relationships with its BLMK partners.

3. Finance Report

I. It was reported that month 2, the Trust is broadly on plan. Within the context of the guaranteed income contract with MKCCG, the focus remains on managing costs efficiently and reducing the cost base. At that point in the year, the Trust was under-performing on the contract with MKCCG but over-performing on other contracts –

MKCCG are aware of this and not currently concerned. Discussions around the 2020/21 contract are likely to start by Christmas.

II. Pay was overspent in month, but this was largely as a result of staff choosing to be paid on a weekly basis. The Trust is also overspending against plan in terms of health care assistants. This is mainly as a result of the use of enhanced observation, and in some cases, HCAs are substituting for registered nurses where this is acceptable.

III. At month 3, the Trust's position is positive to the tune of £37k. However, financial difficulties in other organisations within the BLMK ICS means that the Trust will lose £138k worth of Provider Sustainability Fund monies.

IV. A&E activity was up in month, but non-elective fell. However, July may have been the Trust's busiest ever month for admitted care.

V. Although the Trust is doing well overall, it was noted that activity is below plan. GP referrals now have to go through a Referral Management System which helps ensure that only the most serious cases are sent to the hospital.

4. Agency update

I. The agency spend for month 2 was £727k. however, the Committee noted that quarter 2 could be challenging for medical staffing as vacancies as a result of resignations are sometimes not be filled by the Deanery in July.

II. In month 3, expenditure was once again below plan, although there were overspends in some areas such as therapies. There was once again some concern about medical spend, but there is still expectation that overall spend will stay below plan. It was agreed that efforts would be made to keep spending as low as possible in the first 4 months of the year in case there is a need for extra spending in the winter months. There will also be a focus on earlier recruitment.

5. Transformation Programme

At month 2, £11.5m of schemes had been identified, but a shift from income growing to cost reducing schemes is still required, and there was confidence that the Medicine and Surgery divisions are making this shift. Procurement and workforce related schemes are also making progress. Although there is confidence that the overall £8.4m target will be achieved, it was conceded that most of the savings may not be recurrent. Reference was made to ongoing work in A&E and Urology, for example, where the skill-mix is changing, and the staffing model relies more heavily on nursing.

It was noted that specific work is being done to reference changing processes as a result of eCare. There was confirmation that every CIP scheme is quality impact assessed to ensure that patient safety and care are not affected by the plans. Both the Chief Nurse and Medical Director are actively involved in this process.

At month 3, the Committee noted that of the 4 divisions only Surgery was above target, although the other 3 are working hard to catch up. It was noted that a number of CCG staff are now based at the

Trust, working on new models of care, and specialist support is also being provided to help in dealing with so-called “super-stranded patients.

It was agreed that going forward, a step would be added to the process to ensure that major projects, such as eCare, would be brought back to this Committee 6 to 12 months after delivery to ensure that they are in fact delivering the expected benefits.

6. Timeline for strategic capital projects

I. An outline business case regarding the proposed pathway unit will be presented to NHSI/E and the DHSC once it is ready.

II. The Trust may be in line to receive additional funding under the Global Digital Exemplar programme.

7. Other business

It was confirmed, in relation to scrutiny of progress against the Trust objectives, that there is a timetable in place for reporting back to the Board, and the first feedback session will take place in October.

Milton Keynes University Hospital NHS Foundation Trust

Workforce and Development Committee Summary Report

1. Introduction

The Workforce and Development Committee met on 5 August 2019. A summary of key issues discussed is provided below.

2. Workforce

Staff Story

The Learning and Development Manager attended to provide the staff story. She joined the Trust 3 years ago as an apprentice on the Learning and Development Team, having had a previous career in the retail sector. She had a successful time of this winning the Apprentice of the Year award and taking advantage of a number of training opportunities. She is shortly to commence a management training programme. The member of staff was positive about her experience as an apprentice and highlighted the development opportunities that had been afforded her. In her current role, she is keen to contribute to the Trust's efforts in developing its workforce for the future through arranging work placements and delivering coaching. Her advice to others considering taking up an apprenticeship was that they should seize all the opportunities that are available to them and be proactive.

The Committee thanked the Learning and Development Assistant for attending to share her experiences.

Staff Survey

This discussion focused mainly on the extent to which the Trust's staff are engaged with the organisation as measured by the Staff Survey and the extent to which the Trust has prioritised appropriate actions to drive engagement. The engagement score is derived from three dimensions from within the survey – levels of motivation and satisfaction, involvement and willingness to be an advocate of the service. There is frustration that the Trust remains in the middle of the pack relative to its peers, despite efforts that have been made in recent years to address staff concerns. The question was raised whether the Trust is addressing the correct issues. The Committee chair felt that the static (relative to peers) staff survey results provided evidence that we had not been tackling the correct issues. He also felt that we lacked a) a clear target, b) a proper diagnosis of what was holding engagement back and c) an action plan to drive a step change in engagement informed by diagnostic data and by best practices outside of the hospital

Several points were raised in the course of the discussion, including that:

- The Trust's response rates have been falling every year since the first survey in 2015
- Action plans to address issues raised in the surveys have previously been thematic, but a more targeted approach has been taken in the last 2 years.

The Committee accepted that there is no single initiative or action that could be guaranteed to improve staff engagement. The Event in the Tent was highlighted as an initiative that had not only been successful here at MKUH but has been recognised nationally yet had not supported an uplift in overall engagement. It was also noted that the Trust has implemented a number of measures recognised by NHS Employers as useful in improving staff engagement including the introduction and growth of Greatix, long service awards and greater executive visibility. Last year the Trust launched a Staff Survey Goes Large exercise targeting the 5 areas with the most room for improvement. Based on the feedback from this initiative, a management toolkit has been devised which all managers have been asked to

use when holding listening events for receiving and acting on feedback from their teams this year.

It was agreed that the Trust will have targets to:

- Be among the top 15% of comparable Trusts for staff engagement, and
- Achieve a response rate of over 50% for the 2019 Staff Survey

In addition, further analysis is to be carried out with a view to understanding what would increase engagement, and the Committee will receive updates on the use of the management toolkit and the listening events at future meetings and that insights from this will be used to generate a holistic staff engagement strategy and plan.

Given that the Committee agreed that it would be impossibly for MKUH to become an outstanding hospital without driving engagement to top of benchmark levels it was also agreed that the topic of staff engagement needed more frequent discussion and scrutiny at Board on an ongoing basis.

Organisational Development and Talent Management
The first cohort of participants in the MK Managers' Way programme for new and existing managers have completed the course.

More colleagues have volunteered to participate in the peer to peer listening service (P2P) which has been set up to support staff in a confidential environment. The disability staff network is gaining momentum, and the other networks are also at different stages of development.

Education update
It was noted that the Trust is focusing on using some of the funding that is available through the apprenticeship levy to pay for Masters' level training to equip staff to take on more senior roles. Approved standards and training providers for new apprenticeships are also awaited.

Model Hospital update
The Committee received a presentation on how the Trust compares in terms of its costs to its peers across the workforce components of the NHS England Model Hospital comparative tool. Although the tool indicates that there are some areas, including medical staffing and agency spend, in which the Trust's costs exceed those of other similar organisations, the Committee noted that there are several caveats to the tool – including the age of the data that it relies on, and the fact that trusts often present their data differently, meaning that comparisons are not always valid. Nevertheless, it was noted that work is being done to reduce spend where possible.

Workforce Information Quarterly Report
Highlights from the report include:

- Turnover was down by almost 3%
- The overall vacancy level is 13%, but there are some high vacancy areas in relation to which dedicated work is being done
- Compliance against statutory and mandatory training and appraisal requirements remains high.

Quarter 1 HR Systems and Compliance Report
The main highlight from this report was the improvement in the amount of time it takes to recruit staff. Mention was also made of the actions being taken to fill hard to recruit posts.

Board Assurance Framework
No changes were made to the ratings of any of the workforce related risks, but some amendments were recommended to some of the wording and sources of assurance.

Staff Health and Wellbeing Report
This staff health and wellbeing report included the following information:

- The staff flu vaccination target for this year has increased from 75 to 80%. The Trust has successfully delivered the 75% target in the last three years.

Equality, Diversity and Inclusion update
The Committee received both the Race Equality and Disability Equality Schemes, the latter being presented for the first time. Further analysis of some of the findings needs to be conducted – in particular we need to understand data that suggests that disabled members of staff at this Trust are more likely to endure bullying and harassment than their able-bodied colleagues.

Staff Friends and Family Test
At Quarter 1, 76% of respondents to the Test indicated that they would recommend the Trust as a place to work, while 11% said they would not. 71% also said that they would recommend the Trust to others for receiving care.

The Board is asked to note the summary report.

Charitable Funds Committee Summary Report

1. Introduction

The Charitable Funds Committee met on 1 July 2019.

2. Key matters

The following items were presented to the Committee:

Fundraising update

- The Be Seen In Green campaign ran during the month June to mark the anniversary of the launch of the Cancer centre Appeal. 40 local companies, organisations and schools took part raising around £15k in total. Events that took place during the campaign included a soapbox derby through the city centre. The positive impact that this campaign will have both on the Cancer Centre Appeal and other fundraising activities by the charity was noted.
- Legacies are now being made on behalf of the hospital. A legacy leaflet has been prepared and will be added to the fundraising packs. Relationships are also being built with local solicitors and the Committee will be updated at future meetings on this.
- Potential donors remain willing to support the Cancer Centre Appeal, but progress in accessing funding has been slower than expected. Enquiries have been made regarding room-naming opportunities, and it was confirmed that these will be accommodated in line with Trust policy.
- Sales of tickets for the gala dinner on 13 September have gone well, and as at the date of this meeting almost half of the available tickets had been bought. The point was made that some of the impacts of the dinner would continue to be felt in 2 to 4 years' time.

Charitable Funds Finance updates

- The timeline on spending for the Cancer Centre is being worked through, and as such it is not yet possible to ascertain when the appeal will close.
- A plan for further appeals is to be presented at the Committee's next meeting.
- The non-appeal financial position is stronger than expected with a cash balance of £347k. The strength of predicted grant funding is to be clarified.

Arts for Health

- The Committee received a presentation on the role of Arts for Health. The charity currently curates, cares for and maintains all of the artwork around the hospital as well as 4 of the hospital's courtyards.
- Funding for their work programme for 2019/20 was approved. It was agreed that the Trust will work with Arts for Health on raising their profile and thereby becoming more financially sustainable

Fundraising Practice

The Committee agreed that the Fundraising Practice will continue to support the Cancer Centre Appeal until the end of the year, and they will provide monthly updates on their work to the Committee.

Charity strategy development

- A report will be presented at the next meeting on the development of a strategy for the charity that will focus on sustainability, the management of rises and falls in funding and the development of collaborative working partnerships.
- Contactless tap to give points will be coming on line shortly.

Other business

The Trust Chairman indicated that he had attended a fundraising event for the Cancer Centre Appeal some 8 months ago, but that since then no funds had been received. The matter is to be escalated to the police.

3. Risks highlighted during the meeting for consideration on BAF/SRR

The Trust's responsibilities around the Cancer Centre Appeal.

Audit Committee Summary Report

1. Introduction

The Audit Committee met on 16 July 2019. A summary of the key matters discussed is provided for the Board:

2. Matters Arising

The Committee received an update on the steps being taken to address the risk of cyber-attacks at the Trust. The process of upgrading computers to Windows 365 is continuing at pace, and the Trust is also moving away from password protection towards other forms of identification. As a result of the various measures that are being taken, the Trust is now rated within the top 10 of NHS organisations in the country for cyber-security. Regarding employees who inappropriately access sensitive information, it was noted that the Trust has supported ICO prosecutions against such staff.

3. Data Quality

The Committee received and discussed a data quality improvement project plan highlighting the steps being taken to improve data quality across the organisation. The expectation is that in due course, completion of the actions set out in this plan, along with the management actions from the external auditors could lead in the future to the Trust no longer being qualified following the Quality Report indicator testing. Completion of the administrative transformation programme would also have a role, particularly in relation to RTT. The Committee acknowledged that errors would continue to occur while these long-term actions are being implemented, and there was some debate as to whether this is an acceptable risk. In terms of priorities, it was noted that the focus will remain on A&E, RTT and cancer care – although internal audit could be commissioned to do some extra work in this area. The issue is to be revisited at the next meeting.

4. Internal Audit

The internal auditors presented their 2019/20 plan, highlighting the link between the areas chosen for review and the risks that had been identified in the Board Assurance Framework. It was acknowledged that there had been extensive engagement with the executive team in formulating the plan.

It was agreed that the review of STP/ACS governance would focus more on MK Place, and that the eCARE implementation and benefits realisation would be dealt with together at a later stage in the life of the 3-year internal audit strategy. The Committee also suggested more of a focus on risk management and assurance as against cyber-security and recruitment, the latter two being areas of relative strength for the Trust.

All of the 7 reviews that had been completed as part of the 2018/19 plan, were assessed as providing reasonable assurance, but there were some areas for improvement, particularly regarding data quality and delayed transfers of care. A report on the tracking of the completion of actions is to be presented at the next meeting.

5. Financial Controller Report

Write-offs for the quarter amounted to £88k, £71k of which related to overseas patients (including £20k attributable to a deceased patient). Details of all the cases had been passed on to the Borders Agency.

Losses in the period amounted to £98k, most of which related to obsolete stock identified in the annual inventory. Steps are to be taken to better manage the obsolete drugs produced by the Aseptic Pharmacy Unit, however there is confidence that the core pharmacy stock is well controlled.

In terms of credit notes over £20k, there were 4 in the period, amounting to £172k, and they related mainly to corrections of invoicing errors.

14 tender waivers were completed in the period, totalling £565k, but 3 other waivers were cancelled .

6. Risk

The Committee held a discussion about its role and that of the Board in relation to management of the risk and control environment. The members noted that the CQC had been concerned that the Board did not appear to have sufficient oversight of highly rated risks on the Significant Risk Register (SRR), but they did not consider that in-depth scrutiny of what is an operational risk register would not be an appropriate use of board time. The Committee agreed instead that formal reporting be provided on the escalation of risks from the SRR to the Board Assurance Framework (BAF), as well as on what happens to risks leaving the BAF. In addition, training for managers around risk scoring is to be commissioned, and the Standard Operating Procedure on how the BAF is updated will be re-circulated. The internal auditors also agreed to circulate details of good practice that they had observed elsewhere.

7. Minutes from Board Committees

Minutes of the following Board Committee meetings were presented to the Committee for information:

- Finance and Investment Committee meetings on 1 April, 29 April and 3 June 2019 (approved)
- Charitable Funds Committee meeting on 29 April 2019 (approved)

8. Recommendation

The Board is asked to:

i) Note the report; and
ii) Consider the escalation items and any necessary actions.

Milton Keynes University Hospital NHS Foundation Trust

Quality and Clinical Risk Committee Summary Report

1. Introduction

The Quality and Clinical Risk Committee met on 16 July 2019.

2. Key matters

The following items were presented to the Committee:

Matters Arising

Standards are to be agreed on timings for settling agendas and circulating meeting packs to ensure that Committee members have sufficient time to prepare for meetings and scrutinise the information. It was also agreed that further impetus will be added to the completion of actions around securing improvements to the patient experience.

Quarterly highlights report

- The CQC inspection team had raised two issues for urgent attention while they were on site. One of them had been as a result of a misunderstanding during an interview (warming of fluids), and the other has been addressed (theatre procedure room). Neither issue was referenced in their report. The Committee was informed that the Trust had formally challenged the ratings awarded in respect of Maternity Care and Medicine.
- Six primary care networks (PCN) have been established in MK, and some funding is to be channelled through them. The Trust is working with the PCNs and other local partners to help develop a local clinical leadership forum.
- Feedback received from trainee doctors within the Obstetrics and Gynaecology specialty indicates that they have not been as well supported as they should. Action is being taken to address the issues raised, including standardising processes to facilitate better teamworking, and ensuring that trainees are aware of all the available routes through which issues may be escalated.

Clinical and Quality risks on the Board Assurance Framework (BAF)

Members of the Committee will meet informally to have a more detailed look at the risks owned by the Committee prior to the next formal meeting.

Exception report for Quality Dashboard

- Although significant improvement has been made in respect of patients who have had to endure longer than expected stays in hospital, more work, including with partners, is required, and this is being planned.
- There had been a deterioration in the timeliness of ambulance handovers in May 2018, largely as a result of the introduction of eCARE. Since then, the quality of handover has been steadily improving, although the process is still taking longer than it previously did. Further improvement is expected once ambulance records become available via eCARE.
- Expected improvements in complaint response times have not yet occurred. Most complaints continue to be dealt with and resolved by the PALS office, but there remains a sizeable number of more complex cases that take longer to resolve.

Quarterly mortality update

- The Committee noted the gradual increase in the Trust's Hospital Standard Mortality Ratios (HSMR) score over the last year or so, due largely to issues around coding, particularly in respect of comorbidities and palliative care. The Trust remains within an acceptable range.
- There is one area in which the Trust has been an outlier in terms of the mortality rate – fractured neck of femur. A thorough review took place in respect of a cluster of

deaths to which the Trust was alerted in November 2018. A total of 20 deaths were considered by the Coroner, and although discussions are ongoing, no cause for concern has been raised.
- Qualitative reviews of deaths are being held, but only a very small number have led to lessons being learnt. It is expected that this will improve with the introduction of medical examiners, eight of whom are now in post.

Quarterly trust wide progress report – Serious Incidents
- 13 serious incidents were recorded during the quarter. The top reported category was pressure ulcers, and it was noted that the way in which this category of incident is categorised and reported nationally had changed during the period.
- The Trust is working on new guidelines following a serious incident in which a patient's ovarian cancer went undiagnosed. The mismanagement of a diabetic patient has also resulted in significant learning for staff.
- A number of deaths highlighting issues in the interface between mental health services and the ED are going to inquest in October.

Pressure ulcers quarterly update
- New definitions and guidance on pressure ulcers was issued by NHSI in April 2019, with a view to bringing about a more consistent approach to measurement and monitoring. The changes included abolition of the previous 'avoidable' and 'unavoidable' descriptions, and the introduction of additional categories such as moisture lesion and deep tissue injury.
- There was a reduction in the number of ulcers compared to last year, probably as a result of these changes.
- The Trust is working collaboratively with nursing homes to address the relatively high number of community-acquired pressure ulcers.
- A pressure ulcer panel has been set up to review all cases and assess any emerging themes. The panel reports monthly to the Nursing, Midwifery and Therapies Board.
- The possible impact that moving patients around the hospital could have on the occurrence of pressure ulcers was noted. An alert is to be added to eCARE to make the site team aware of how many times a patient has been moved.

Review of the 2018/19 Quality Report
The Committee was informed that as a result of the timing of the local elections, it had not been possible for local authority partners to provide detailed comments on the report ahead of submission to NHSI in May. The feedback from the auditors about the delay in receiving a compliant version of the report was also noted – this had largely been as a result of the CQC inspection process which occupied the time of several contributors at a crucial point in the process. Early consultation with this Committee and the Council of Governors is to begin in November 2019.

Committee familiarisation session – infection Control and Antimicrobial Stewardship
- This team had been invited to present to the Committee in recognition of the important work that they do.
- The Trust is mandated to report antibiotic consumption per 1000 patients on a quarterly basis. The consumption level is below average, but there is an expectation that it should be even lower. There is a particular focus on Respiratory Medicine where usage is high.
- Antibiotic ward rounds are taking place during which any patients who have been on antibiotics for more than 72 hours are reviewed. In 75% of such cases, the antibiotics being used are either changed or the length of use defined. In the remainder of cases, the use was stopped.

- Anti-microbial stewardship at the Trust has improved significantly compared to the position a few years ago.
- Regarding infection control, there are 3 consultant microbiologists in place, supporting the nursing team. The latter are focused on staff education and patient management.
- There is a risk that the ability to manage pan-resistant bacteria could be lost.
- The team is working closely with Hotel Services to ensure that the Trust maintains a clean environment. Work is being done specifically with the Trust's 200 cleaners to help improve their understanding of where the threat lies and the importance of their role in reducing it. The inclusion of cleaning in the Trust objectives underlines its importance in infection control.
- In relation to community acquired infections, the Trust works with CNWL and the CCG around reportable organisms from inpatient areas. Where pan-resistant patients are imported, the team liaises with Public Health England and the rest of the Trust.

Annual Reports
The Committee received and considered the:

- Annual Complaints Report 2018/19
- Clinical Audit Forward Plan 2019/20
- Annual Claims Report 2018/19, and the
- Research and Development Annual Report 2018/19.

In particular, it was noted that:

- The number of complaints received continues to rise
- The Trust has a good record of initiating audits but currently performs less well at logging their completion and monitoring action plans.
- Clinicians are appropriately involved in the process of litigating claims, although they are not always content with the eventual outcomes.
- Positive progress continues to be made on Research and Development.

Other matters
For the future, agendas for meetings of this Committee will be more closely aligned to the Trust objectives.

3. Conclusions
The Committee was assured that the hospital remains safe and commended the engaged and professional executive team.

The Board is asked to note this report.