TheMKWay

CARE. COMMUNICATE.
COLLABORATE. CONTRIBUTE.

NHS

Milton Keynes
University Hospital

NHS Foundation Trust

2019/20

# MKUH Quality Report

# Contents



# 1.
# The Quality Account



# 1.1 Introduction

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

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

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

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

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

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

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

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

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

## The Trust's values are:


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

One of the requirements in compiling the Quality Report for the previous financial year (2019/20) is to select at least three quality priorities for the year ahead (2020/21). These priorities are included in Part 2 of the Quality Report.

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

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

Once agreed the Quality Report must indicate how the priorities will be met, monitored, measured and reported by the Trust. The Quality Report provides an evaluation of progress in meeting the quality priorities set for 2018/19 and gives a general overview and evaluation of how well the Trust has performed across a range of quality metrics throughout the year.

*"We aim to provide quality care and the right treatment, in the right place, at the right time"*

# 1.2 Statement on Quality from the Chief Executive

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

**This important document gives us the opportunity to reflect on all we have achieved in improving the quality of care provided to our patients during 2019/20. It also allows us to identify where we will focus our efforts next year in order to make the care and experience we provide as safe, as positive and as effective as it can be.**

This year, the Quality Report is different to normal due to the challenges MKUH, and all NHS Trusts, have faced due to the unprecedented pressures posed on us by the Covid-19 pandemic, which had a major effect on services from early March 2020. Usually the Quality Report is an integral part of the Annual Report and Accounts, which, for 2019/20 were produced in June 2020. Initially our regulators, NHS Improvement, dispensed with the need to produce such a report, but following further consideration, they determined that a report should be made available by the end of December 2020, with the proviso that there was no requirement for the Quality Report to be externally audited.

It does seem somewhat unusual to produce a report for a period, that, due to the pandemic, now seems such a long time ago. It does also mean that the three quality priorities agreed by our formal Council of Governors in February 2020 may change as the year progresses due to other pressing requirements as the Trust works hard to return the site to running our patient services as close to normal as we possibly can while bearing in mind that Covid-19 is still very much going to be a consideration in our services for the foreseeable future.

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

Aside from the pressures that Covid-19 brought in February and March 2020, 2019/20 as a whole was a very exciting year of developments at the hospital. Once again, we continued to invest in the development of our staff, our services and the estate itself, with the aim of further improving both quality of care and the availability of services to the people of Milton Keynes and surrounding areas.

One of the biggest investments we made in 2019/20 was construction of a dedicated purpose-built Cancer Centre. The centre opened in March 2020 and saw all our on-site cancer services brought under one roof.

This was a major undertaking and we are grateful to Milton Keynes council for their £10million donation, Macmillan Cancer support, who donated £2 million and the people of Milton Keynes who tirelessly supported our Hospital Charity to help raise more than £800,000 of the remaining £2.5 million. The Cancer Centre has its own 28-bed ward upstairs, while on the ground floor there are outpatient areas for oncology, clinical haematology and cancer-related chemotherapy, along with an area dedicated to health and wellbeing. There are also offices and a brand new aseptic suite for the manufacture of the specialist drugs that are required. The Cancer Centre has its own patient parking area and is linked to the main hospital by a purpose-built corridor.

In terms of developing our estate to support better patient care and experience, in the coming year work is also due to start on the development of a same day emergency care unit.

We are also developing plans for what we hope in the future will be a new Women's and Children's Hospital and surgical block. This continued investment in estate reflects the growth of Milton Keynes as a town. With 2,900 homes being built each year, the town is predicted to have a population of 500,000 by 2050 and we recognise that we must keep apace of the growth in demand as Milton Keynes becomes such a popular home for people of all ages.

We also continued to focus on technology to improve patient experience. After its successful launch in 2018/19 our plan was to continue the roll out of our eCare (electronic patient records) system throughout the year, with the final cohort of departments, including critical care and paediatrics, to move over to eCare later in 2020. This has now been postponed to enable the hospital to dedicate resources to responding to the Covid-19 pandemic. However, when this digital system is rolled out, it will significantly improve the way patients are seen and treated. In the areas where eCare is already in use, it allows our staff to treat patients more effectively by providing them with easier access to up to date information that can be shared in real time across all departments.

We continued to invest in several other digital platforms. MyCare is our patient portal which allows patients direct access to cancel or change appointments without the need for a lengthy telephone call. Our two maternity apps, one for patients with hypertension and another for patients with gestational diabetes are proving very helpful to patients. These allow patients to carry out checks via the app from the comfort of their own homes and transfer the information to midwives on site, who can follow up the results if needed.

In order to enhance the parking situation for both patients and staff, we built a staff-only multi-storey car park at the back of the site during 2019/20 and created increased parking spaces for staff by changing part of the hospital ring road to one-way to allow for on-road parking. This resulted in more spaces being freed up for patients and visitors. During 2019/20 we also introduced ANPR (automatic number plate recognition) to make parking easier.

Demand on the hospital's services continued to increase during 2019/20. We processed 24.2% more GP referrals than had been planned for, and demand on the Emergency Department was 0.9% higher expected, with increasingly complex and acutely unwell patients. The impact of Covid-19 affected activity volumes in March 2020. The Trust accommodated 9.3% fewer emergency admissions through the year than planned, which was a decrease of 15.7% compared to 2018/19. The reduction in emergency admissions was influenced by the evolution of the Ambulatory Care pathway.

The Trust did not achieve the target of treating 95% of patients attending the Emergency Department within four hours. However, its overall performance of 88.7% (all types) for the year placed it among the top 25% of performing Trusts with a Type 1 department nationally for this measure.

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

We have been working during 2019/20 on the actions that need to be taken to enable the Trust to meet the clinical standards developed in 2013 for seven-day services within hospitals. The steps that need to be taken to meet the requirements of the four priority standards have been identified and the additional investment that will be required has been quantified. Those interventions that have been identified as first order priorities are to be progressed, subject to approval through the Trust's normal governance mechanisms, as we move into 2020/21.

We are committed to continuing to improve the quality of the care we provide. Each year we challenge ourselves to do better so that our patients get the best possible care, treatment and experience whilst in our care or using our services. We are aware that in 2019/20 we received around 12.2% fewer complaints about our services than we did in the previous year. We welcome the feedback and the opportunity to do better for our patients. Since our PALS office has been situated in the main entrance of the hospital we are receiving more feedback, which is good news. We are working hard to improve the experience that our patients receive when they use our services and this will continue to be our priority in 2020/21.

# 1.3 Statement of Assurance

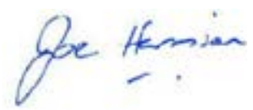
**There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:**

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

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

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

The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to the best of my knowledge, the information in the document is accurate, with the exception of ongoing data quality issues identified in the Annual Governance Statement (Annual Report).



**Joe Harrison**
***Chief Executive***

October 2020

# 2. Priorities for improvement and statements of assurance from the Board

# 2.1 Priorities for Improvement in 2020/21

**This section of the Quality Report describes the areas we have identified for improvement in 2020/21. In February 2020, these priorities were shared with and agreed by our Board of Directors (Trust Board) and Council of Governors – a body made up of elected members of staff, members of the public and nominated stakeholder representatives.**

The priorities for 2020/21 were agreed prior to the outbreak of the pandemic and therefore may be subject to revision/assessment during 2020 as the Trust deals with conflicting demands and priorities while maintaining the provision of services.

The first priority, improvements in the management of medications and outcomes for admitted patients with diabetes, is an area that has the potential to provide significant improvements in patient safety. The second priority, which is a continuation of one of last year's priorities around reducing high Did Not Attend (DNA) rates, focuses further on improving efficiency in the Outpatients Department – this will improve operational effectiveness. The third priority – on reducing the length of inpatient stay for some patients, focuses on improving patient experience by ensuring that patients only stay in hospital as long as they medically need to do so.

## Priority 1: Improving Care for Inpatients with Diabetes

- Reduce harm from failure to recognise and respond appropriately to both high and low glucose levels.
- Improve the experience of patients with diabetes and empower them to be self-managing whenever possible.

### Why have we selected this priority?

Failure to act or recognise and respond to both high and low glucose levels can have serious implications for patients with diabetes and can result in patient harm. Our monitoring of patient safety incidents shows that a significant number of incidents are related to delays and poor management of hypoglycaemia episodes following glucose monitoring and medication administration errors related to the administration of insulin.

Approximately 1 in 6 people admitted as inpatients to our hospital have diabetes. The majority of our patients are admitted for a variety of medical reasons rather than specifically for the management of their diabetes which adds to the complexity of delivering excellent patient centred care for patients with diabetes.

### What is our past performance in this area?

Having engaged with both GIRFT (Getting it Right First Time) and the National Diabetes Inpatient Audit programmes we understand the areas that we are performing well in and those areas that require improvement. Ninety percent of our patients report they are satisfied or very satisfied with their overall care and eighty percent of patients thought all or most of the staff caring for them were aware that they had diabetes

We have a low incidence of severe hypoglycaemic episodes and normally provide appropriate blood glucose management. We need to improve on the management of mild hypoglycaemic episodes and increase the percentage of 'good diabetic days' (defined as any day in a patients hospital stay where records show that blood sugar levels was never less than 4mmo/L and there was no more than two readings showing blood sugar levels higher than 11mmo/L).

### How will we monitor and measure our performance in 20/21?

We have set up a diabetes improvement project team. Members include the diabetes specialist clinicians, pharmacy, transformation, patient representatives and have focused the project on one of our medical wards where patients with diabetes are predominantly cared for at MKUH.

We have determined the parameters that can be used as measurement of diabetes management on the wards. The parameters are:

- Hypoglycaemia (blood glucose < 4mmols) - reduce frequency
- Hypoglycaemia – Management of and time taken to resolve per patient
- Hyperglycaemia (blood glucose > 11mmols) – reduce frequency (no more than 2 readings)

We plan to improve diabetes education and build upon the success of 'Think Glucose' national initiative led by the NHS Institute for Innovation and Improvement which aims to improve inpatient diabetes care using of the expertise of the inpatient diabetes specialist teams.

Learning from incidents relating to low and high blood sugars and medication administration errors will be shared in arenas across the wider Trust.

We need to improve on the timing of insulin administration through education and promoting self-administration for able patients to maintain their independence and self-management.

We have and will continue to complete yearly notes audit looking at the documentation of hypoglycaemic management and use this to guide improvement in our processes and pathways.

We will engage patients in our project to ensure the voice of the patient is at the heart of our improvement plan and delivers our ambition that people with diabetes always know what care to expect when they are in our hospital. Including feeling able to ask questions, confident that those caring for them understand their needs and importantly always feel safe. We know we often meet these standards of care for our patients and we aim to do better and make sure we *always* do.

## Priority 2: Improvements in Outpatients efficiency

This is a continuation of one of the priorities for 2019/20, including efforts to reduce high Did Not Attend (DNA) rates which weren't necessarily the patients' fault as other metrics were involved, e.g. timing of letters, changing of appointment dates.

### Description of the priority:

Outpatient activity has grown faster than all other hospital activity in the last 10 years. In 2019/20 there were 383,764 outpatient attendances and with the growth of the town this is predicted to increase year on year. There continues to be scope for improvement in outpatients which will make the experience better for both the patients and staff and will greatly improve the efficiency of how the service operates. The work is effectively split into 2 key areas – digital advancement and operational efficiency.

The digital road map continues to make great progress with developments in eCare, Synertec and MyCare which are transforming communication into paperless processes.

The operational efficiency is focussed on developing robust metrics and dashboards to better understand efficiency and improved utilisation.

### Why have we selected this as a priority?

We have continued to focus on Outpatients efficiency as a priority because we know there is greater opportunity to be captured to improve patient experience and be more efficient across processes and our interfaces with patients and the public. Patient feedback tells us there is more to be done.

### What is our past performance in this area?

The Trust has a good track record in advancing technology and becoming digital. The implementation of eCare in May 2018 started much of this journey. Our new patient administration service (RPAS) was paused due to Covid-19 but will be rolled out during 2021 and lead to significant improvement to current Outpatients Department processes. The future development of automated dashboards with good operational metrics, will provide greater corporate oversight and add value and efficiency to the delivering good quality services for patients.

### How will we monitor and measure our performance in 2020/21

Both the digital improvements and operational efficiency of Outpatients will continue to be monitored by the monthly Transformation Board.

Outpatient performance KPI's (key performance indicators) and metrics continue to be reported on both the Trust Performance dashboard and Divisional dashboards.

Divisional performance is challenged and scrutinised via monthly Management Board meetings with the Executive team.

Trust Planned Care Board has also been brought into operation to better scrutinise and co-ordinate delivering performance and strategy.

## Priority 3:
## We will reduce length of stay for our older patients

### Description of the priority

There are many reasons why a hospital discharge for an older person is not straightforward. We have introduced a programme of work to understand and address these issues with the aim that we reduce the number of patients still in hospital once they are medically fit for discharge. We also want to reduce the number of beds occupied by patients with a length of stay of 21 days or more.

### Why have we selected this as a priority?

Long stays in hospital introduce the risk of functional decline in people over the age of 70. Patients in this age group occupy around 56% of the beds in our medical and surgical wards. Functional decline can be caused by inactivity and sleep deprivation, and increases the risk of falls and fracture, prolonged episodes of acute confusion and hospital acquired infections. For this reason, we need to work with patients and their families so that people only stay in hospital until they are medically fit for discharge.

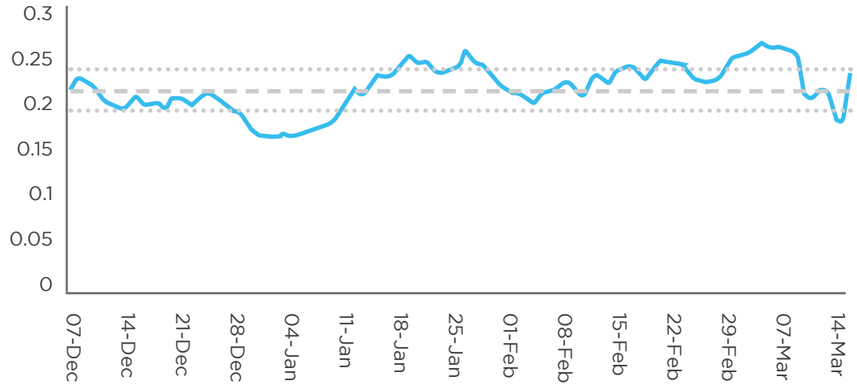
National audits looking at reasons for longer lengths of stay typically show that up to half the reasons why patients are not discharged earlier are under the direct control of the hospital itself. We are therefore supporting wards to adopt and embed proactive approaches to managing patient pathways and are looking for real-time data highlighting local constraints so we may capture the system issues that need to be addressed.

By reducing long lengths of stay for medically fit patients we will not only improve the experience for patients and reduce the risk of harm, functional decline and/or loss of independence; we will aim to keep patients on their speciality wards, remove the need for escalation beds and reduce 'on the day' cancellation of inpatient surgery.

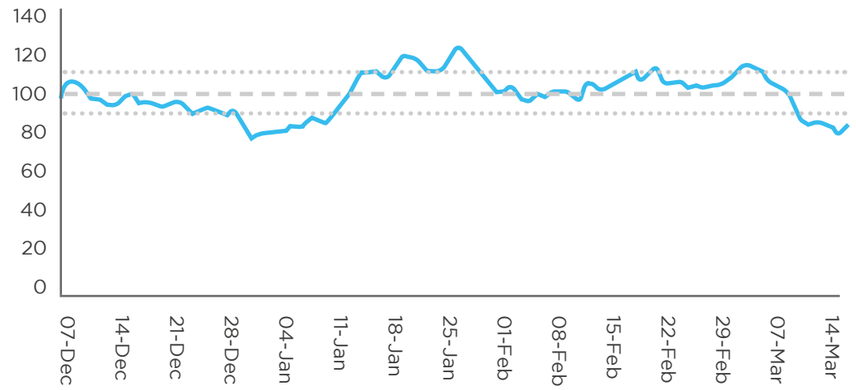
### What is our past performance in this area?

Compared with other similar Trusts in the region, MKUH does need to reduce the length of stay for patients admitted in an emergency. We have higher numbers of patients staying over 21 days, particularly in medical beds. We could also do better when comparing our performance on length of stay for people admitted with two or more frailty indicators.

**MKUH % bed occupancy for patients with length of stay 21 days and over**




**Numbers of patients with length of stay 21 days and over at MKUH**




### How will we monitor and measure our performance in 2020/21?

We will introduce ward level dashboards to be refreshed on a weekly basis and showing performance against ten key improvements.

We need to ensure:

- Discharge is planned from the point of admission
- Consistent and early identification/ management of frailty and potentially complex discharges
- Meaningful Patient Discharge Dates (PDDs) are set be senior clinicians within 14 hours of admission
- Criteria for discharge is agreed and documented
- Daily board rounds are led by senior decision makers
- Patients do not move inpatient wards unnecessarily
- Patients are transferred to the Patient Discharge Unit or discharged home by 10am
- Patients are moved from assessment units to inpatient wards by midday
- Take home prescriptions are on the ward by 5pm the day before discharge

A combined version will be held centrally and reported on by the Transformation Team.

### How will we report our progress against achieving this priority?

Progress will be reported on a monthly basis to the Transformation Programme Board through the Length of Stay Programme Board.

# 2.2 Our Performance against Priorities for Improvement in 2019/20

**Priorities for 2019/20:**

1. **Positive patient identification (PPID) for Medication Administration**
2. **Turnaround times for patient discharge medication**
3. **Reducing the number of 'did not attends'**

## Priority 1: Positive Patient identification (PPID) for Medication Administration

### Description of the priority

We will monitor our compliance with Positive Patient Identification (PPID) to ensure the scanning of the patient's wristband prior to medication administration is completed on all possible occasions.

### Why did we select this as a priority?

Patient misidentification has been recognised as an error that can lead to administration of medication to the wrong patient and therefore constitutes a serious risk to patient safety. The ability to correctly identify the patient is the first step in reducing patient mismatch errors.

Scanning the patient's wristband prior to medication administration ensures that the patient and the drug chart that is open are a match and supports the 'five rights' of medication administration: Right patient, Right medication, Right dose, Right time and Right route.

### What was our past performance in this area?

Positive Patient Identification is completed for over 75% of administrations in those areas live with eCare with some areas achieving over 90%.

### How did we monitor and measure our performance in 2019/20?

- Reported monthly quantitative data of patient scanning
- Reported monthly quantitative data of mismatch records
- Reviewed medication administration workflows to ensure they supported the use of PPID
- Worked with colleagues across the Trust to identify areas of improvement for departments or individuals.

### How did we report our progress against achieving this priority?

We report monthly to Nursing, Midwifery and Therapies Board (NMTB) throughout the year, and will provide a detailed narrative report on our progress against the goals set out in June 2020.

## Priority 2: Turnaround Time for 'To Take Out' Drug Prescriptions

### Description of the priority

Hospital inpatients are often prescribed drugs for when they are discharged. This prescription, in hospital shorthand, is called a 'TTO' – 'To Take Out'.

There can be a delay in receiving these TTOs leading to a delay in the patient being discharged from hospital. The TTO process is complex and delay can be caused at any stage of the process – at the prescribing stage, the validation stage and the distribution stage.

### Why did we select this as a priority?

The delays at any stage of the process can cause difficulties for the patient, carers and/or relatives, transport and the hospital wards - for the patient as they are anxious to be discharged, for the carers and/or relatives as the uncertainty may require changes in logistics, transport arrangements may need to be changed or even abandoned and for the hospital wards as there may be other patients awaiting that hospital bed.

### What is our past performance in this area?

There has been some previous manual data collection, but this is being further developed from eCare data. For instance, we have data that shows that 41% of TTOs are prescribed the day before discharge, and that it takes an average of 2 hours for the pharmacists to validate the prescription.

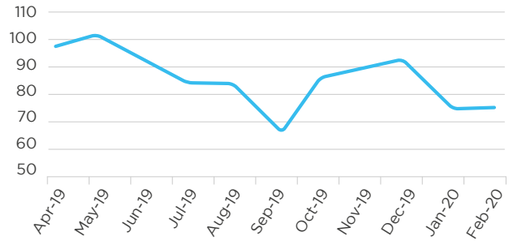
### How did we monitor and measure our performance in 2019/20?

A working group was established to look at the data available to support work on TTO turnaround. Pharmacy produced some data, but it has proved difficult to pull and share data from multiple systems across the Trust. Pharmacy produced data would indicate that time of writing of TTOs has remained consistent and the time the TTO is submitted to the dispensary by the Pharmacist has been brought forward slightly in the day. The time taken to validate a TTO by the pharmacist has also remained consistent.

The Pharmacy department has undertaken a number of initiatives to reduce TTO turnaround during 19/20, some of which have made a difference, others less so. A complete refurbishment of the Pharmacy Department and started in November 2019 and the changes will enable us to streamline all medicines related workflows and is expected to reduce dispensing times.

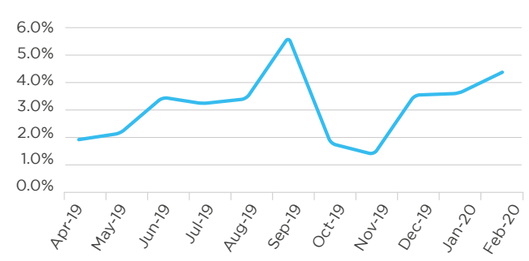
Changes to arrangements within the department during the build have given the opportunity to trial different ways of working in preparation. Co-location of Pharmacist, reception and dispensary in particular seems to have resulted in a reduction of the time taken from receipt of the TTO in pharmacy to it being finally checked and ready for delivery to the ward.

**Dispensing times (mins) for TTO's**




At ward level, we appointed two Band 3 Pharmacy Medicines Management Assistants (MMAs) in 18/19. They cover wards 1,2,15 and 16. Their role is to support all aspects of medicines supply to these wards. During 19/20 they have been using a dispensing cart to enable them to dispense simple TTOs at ward level rather than sending the TTO to Pharmacy. There is good evidence that this is a quicker way of processing simple TTOs. As a result, we have seen an upward trend in the number of TTOs dispensed at ward level which will have resulted in a reduction in TTO turnaround time.

**% of total TTO items dispensed though pharmacy carts**




### How will we report our progress against achieving this priority?

Plans for 2020/21 include:

1. Full process map of the TTO pathway from decision to discharge, through prescribing and dispensing to the TTO being available on the ward – bringing together the data points in different systems to facilitate key performance indicators that are meaningful to patients and carers.
2. Consideration of implementation of a new quality improvement process in Pharmacy to empower staff to make quick changes and improve workflows.
3. Improved data availability.
4. Recruitment of Pharmacy technicians to reduce the time taken for Pharmacy validation prior to the TTO being ready to dispense.

## Priority 3:

### Reducing the number of 'Did not attends'

**Description of the priority**

Did Not Attend (DNA) rates relate to the proportion of patients booked to attend an outpatient clinic who do not attend and have made no contact with the Trust. This results in wasted clinic slots which could potentially have been utilised by another patient. DNAs therefore impact negatively on the Trust in terms of clinic efficiency

**Why did we select this as a priority?**

We want to ensure that patients have a positive experience and are able to access appointments effectively and efficiently. We also have a statutory duty to manage the time patients wait for treatment under the NHS constitution. During the previous year, we saw a rise in the number of patients who do not attend. We wanted to reverse this trend to ensure the most effective use of clinical resources; that patients are not waiting for treatment longer than necessary and that our waiting lists are managed as efficiently as possible.

**What was our past performance in this area?**

Between April 2017 and March 2019, DNA rates overall appear to have increased from around 5.5% to just over 7%. Detailed analysis was undertaken to understand the reasons that may lie behind this increase to ensure that interventions to support a reduction in DNA rates are targeted and appropriate.

**How did we monitor and measure our performance in 2019/20?**

DNA performance in 2019/20 was monitored monthly by the Trust Board. It is a KPI on both the Trust Performance dashboard and Divisional dashboard.

The DNA threshold for 2019/20 was set at 5%. In January 2020 the rate was 7.9% and by March was 8%.

The fear of attending hospitals during the COVID-19 surge definitely had an impact on DNA rates at this time. During the peak of the surge OPD (Outpatients Department) activity was cancelled.

**How did we report our progress against achieving this priority?**

Progress against this priority was reported via Transformation Board. Divisional performance is challenged and scrutinised via monthly Management Board meetings with the Executive team.

> *"The fear of attending hospitals during the COVID-19 surge definitely had an impact on DNA rates at this time. During the peak of the surge OPD (Outpatients Department) activity was cancelled."*

# 2.3 Statement of Assurance from the Board of Directors

**During 2019/20 Milton Keynes University Hospital NHS Foundation Trust provided and/or sub-contracted 37 relevant health services.**

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

The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by Milton Keynes University Hospital NHS Foundation Trust for 2019/20.

### 2.3.1 Clinical Coding Audit

During 2019/20, Milton Keynes University Hospital was not subject to the Payment by Results clinical coding audit.

### 2.3.2 Submission of records to the Secondary Users Service

Milton Keynes University NHS Foundation Trust submitted records during 2019/20 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

### 2.3.3 Information Governance Assessment Report

The Trust completed and published its Data Security and Protection Toolkit assessment for 19/20 on 30/9/20 and has achieved 'Standards Met.'

# 2.4 Participation in clinical audits

**Participation in Clinical Audit and Clinical Outcome Review Clinical Audit is a quality improvement process that is defined in full in "Principles for Best Practice in Clinical Audit" (HQIP 2016).**

The programme allows clinicians and organisations to assess practice against evidence and to identify opportunities for improvement. Milton Keynes University Hospital NHS Trust is committed to undertaking effective clinical audit and quality improvement within all of the clinical services in order to inform the development and maintenance of high-quality patient-centred services. The NHS England Quality Accounts List is made available each January, comprising national audits, clinical outcome review programmes and other quality improvement projects that NHS England advises Trusts to prioritise for participation during the forthcoming financial year.

There are a total of 29 National Clinical audits listed with HQIP. Some of these National Clinical Audits have multiple components, so in total there are 41 separate audits that MKUH can effectively participate in. During 2019/20, MKUH participated in 95% (39 out of 41) of these eligible national audits. There is evidence of good practice, learning and action planning from the National Clinical Audit programme across the organisation. Performance and support for both NCA participation and implementation of service development is offered via the Clinical Audit & Effectiveness Board and the Clinical Service Units.

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

## 2020 National clinical audit participation

| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | Yes | Continuous data collection. | Trusts are not identified in the reports, but recommendations are presented and followed. | Recommendations included in CSU review. |
| BAUS Urology Audits: Nephrectomy | Yes | The nephrectomy audit in MK for 2019 has been submitted and it is complete.<br>There are 19 nephrectomies / roureterectomies. | No annual report | The BAUS Audit Steering Group has taken the decision to close the nephrectomy, radical prostatectomy, cystectomy, PCNL and urethroplasty registries on 31 December 2019. 2017-2019 data for these registries will be published in 2020. The Surgical for Stress Urinary Incontinence (SUI) in Women audit will close on 31 December 2020 and will be replaced by a national pelvic floor registry, following the recommendations of the Cumberlege report in July 2020. |
| (continued) | | | | As yet report not published.<br>The registries will be replaced by a series of "snapshot" audits that aim to identify best practice in specific areas, and which will fulfil training & appraisal requirements for participation in national audits by trainees & Consultants. |
| BAUS Urology Audits: Percutaneous Nephrolithotomy | Yes | Continuous data collection | No annual report | The BAUS Audit Steering Group has taken the decision to close the nephrectomy, radical prostatectomy, cystectomy, PCNL and urethroplasty registries on 31 December 2019. 2017-2019 data for these registries will be published in 2020. The Surgical for Stress Urinary Incontinence (SUI) in Women audit will close on 31 December 2020 and will be replaced by a national pelvic floor registry, following the recommendations of the Cumberlege report in July 2020. As yet report not published.<br>The registries will be replaced by a series of "snapshot" audits that aim to identify best practice in specific areas, and which will fulfil training & appraisal requirements for participation in national audits by trainees & Consultants. |
| National Bowel Cancer Audit (NBOCAP) | Yes | **128**<br>(01/04/2017 – 31/03/2018) submitted in 2019.<br>Data Source: National database<br>Criteria: Diagnosis and Tumour from extract<br>National Gastrointestinal Cancer audit (NGCA) data | Adjusted 30-day unplanned readmission rate 9.6% (national average 10.8%)<br>Adjusted 2-year mortality (%) 24% (national average 18.9%)<br>Patients with complete pre-treatment staging & recorded performance status 100% (green) | This audit forms part for the National Gastrointestinal audit programme.<br>Annual report and Local data are due for review at the next Bowel Cancer MDT.<br>Details for both audits provided. |

| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| (continued) | | **167**<br>(01/04/2017 – 31/03/2018) submitted in 2019<br>Data Source: National database<br>Criteria: Diagnosis and Tumour from extract. | Data completeness for patients having major surgery 70% (amber). | |
| Cardiac Rhythm Management (CRM) | Yes (in discussion) | Not available | | Participation is being scoped by the team. |
| Case Mix programme (CMP) ICNARC | Yes | Awaiting numbers from RS | Decrease in the out of hours discharges.<br>Increase in unplanned & high-risk sepsis admissions. | NEWS 2 audit to inform sepsis ward review.<br>Out of hours discharges reduced following team review. |
| National Paediatric Diabetes Audit Diabetes (NPDA) | Yes | Continuous data collection | Poor levels of thyroid and coeliac screening at diagnosis<br>No CHO counting at diagnosis<br>Small numbers using Continuous Glucose Monitoring (CGM)<br>Data suggested > expected high/ normal and high blood pressure (BP)<br>Data demonstrated higher than expected overweight and obese patients | Increased vigilance of screening tests at diagnosis by consultants and repeat of samples if necessary<br>Review of dietetic WTE and business case underway for further dietetic time<br>Training for staff in use of CGM & increased information to parents of CCG funded CGM<br>Changed practice of BPs at all clinic appointments and did solely in > 12 years at annual review to minimise 'white coat hypertension'. 24Hr BP monitoring undertaken if persistent on repeat in clinic or at GP<br>Increased referrals to CCG weight management service<br>& increased scrutiny of BMI in clinic and referrals to team dietician. |



| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| Elective Surgery Patient Reported Outcome Measures (PROMs) | Yes | Continuous data collection | Adjusted average health gain in 2019 report 23.0 (England average 22.2).<br>Next annual report due February 2020. | Report from 2019 was reviewed. Orthopaedic Surgeon uses local data to review the service this has resulted in improvements to the service in the past. Return of forms is encouraged and supported by the Physiotherapy Team. |
| Falls and Fragility Fractures Audit programme (FFFAP) | Yes | National falls audit - 16 cases submitted<br>NHFD – 300 cases<br>FLS – 295 cases | Programme includes national hip fracture database (NHFD), fracture liaison service database (FLS-DB) and national audit of inpatient fall.<br>There was a drop in the KPI's data, for the NHFD, within patient's documentation due to the change from paper to electronic patient records.<br>Delay in getting patients to theatre. | Consideration to taking down elective lists to fit more trauma work.<br>Work project commenced with the transformation team to help reduce the length of stay (day zero mobilization & Occupational therapists' complete functional needs assessment within 4 days of surgery to identify potential care needs early). |
| Head and Neck Cancer Audit (HANA) | N/A | MKUH does not participate due to low numbers | | |
| Inflammatory Bowel Disease (IBD) programme | N/A | Continuous data collection | No results as yet | Team involved in review of patient pathway. Telephone consultations successful in connecting with patients. |
| Learning Disability (LD) Mortality Review Programme (LeDeR) | N/A | Continuous data collection | | Medicine and Surgery Divisions ensure review of LeDer deaths where these have been identified.<br>Information now provided through Microsoft Power BI. 9 deaths since March 2020. Limited numbers before this date. |

| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| Major Trauma Audit (TARN) | Yes | TU02a All TARN patients submitted – an improvement from 76% in Q3 to 100+% (i.e. more than expected) in Q4, with 74 submitted against an expected 57 cases. | Awaiting additional information from TARN Coordinator. | The most recent Trauma Unit TARN dashboard for Q4 (Jan – March 20) was published in October 2020. The overall message is that MKUH is within or above the expected range for all indicators.<br><br>TU01 Data quality is at 92%, which is within the expected range. Most missing data is from time of injury (which cannot often be ascertained) and injury detail (why we need a process to get timely details of head injuries on CT scans) and clear record of GCS and pupil reactivity on arrival in ED (NB these last two categories do not apply to many submissions but they are still the most frequently occurring missing fields).<br><br>TU02a All TARN patients submitted – an improvement from 76% in Q3 to 100+% (i.e. more than expected) in Q4, with 74 submitted against an expected 57 cases.<br><br>TU02b Patients submitted within 40 days – another improvement with 90% submitted within the target 40 days.<br><br>TU05a Deliver consultant led trauma teams within 30 mins for pre alert /trauma team ISS>15 patients – a slight improvement from 67% to 75% (against national mean of 38.5%) although numbers of patients were small at only 4 relevant patients.<br><br>TU08 Patients with GCS<9 intubated within 30 mins is 25%, however this only elates to 8 patients. On investigation, 3 of these were DNACPR which when removed from the dataset means the real percentage was 40%, around the national mean. |

| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| Maternal, Newborn and Infant Clinical Outcome Review Programme | Yes | Continuous data collection | Awaiting audit presentation – to be presented in March audit meeting | |
| National Audit of Breast Cancer in Older Patients (NABCOP) | Yes | **259**<br><br>(01/04/2017 – 31/03/2018) submitted in 2019.<br><br>Patients 50 years and over<br><br>Data Source: COSD | Team experiences challenges with data entry – documentation of patients who undergo radiotherapy externally is not being captured and it is this this aspect of the audit that identifies the Trust as an outlier. | The last national report published in March 2019 this was presented in June 2019 to Breast MDT.<br><br>Actions: Breast Care Team and Cancer Services to improve accuracy of documentation although this is improving, the receptor status is still not being captured. This is being addressed with external provider. |
| National Audit of Dementia | Yes | Not available | MKUH assessed for delirium in 22% of cases (58% national average),<br><br>14% of cases took collateral histories (31% national average).<br><br>A high percentage reporting of details that aid with communicating with the patient.<br><br>In-hospital falls are now better documented compared to round 3. | MKUH was significantly higher than the national average regarding the collection of a patient's personal preferences.<br><br>An area of improvement was the collection of information regarding the factors that cause patients' distress.<br><br>Staff training for dementia awareness was overall usual to the national average A high percentage of our staff did not receive dementia training (17% compared with 8%).<br><br>eLearning training was one area where the hospital fell far short of the national average. |

| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| National Audit of Rheumatoid and Early Inflammatory Arthritis. | No | Continuous data collection | QS1 - 25% out of our hands- reliant on GP timely referrals.<br>QS3 - 73.3% not far from target (80%)<br>QS4 - 100% (above target 80%)<br>QS5 - 96.7% (above target 80%)<br>QS6- 100% (above target 80%)<br>QS7 - 13% not currently carrying out annual reviews as BSR require, need to have specific assessments completed (QRISK3, FRAX etc.) | Report reviewed in October 2019. MKUH alerted by British Society of Rheumatology (BSR) as being outlier for QS2 - 50%.<br>Plan was to instigate specific early inflammatory arthritis (EIAA) clinics from January 2020 whereby audit with be completed as part of this.<br>Covid-19 surge plans included Rheumatology doctors and nurses therefore data submission delayed. Nurse vacancy has also impacted completion on return of services. |
| National Audit of Seizures and Epilepsies in Children and Young People | Yes | Continuous data collection | No data as yet | |
| National Cardiac Arrest Audit (NCAA) | No | Currently collected | Local results under review | Presented at Critical care delivery group. Actions relating to standardizing the trolleys and education. |
| National Chronic Obstructive Pulmonary Disease Audit programme (COPD) | Yes | Continuous data collection | Met best practice tariff (BPT) continuously since January 2019.<br>Noninvasive ventilation (NIV) – variable but generally above national average.<br>Smoking cessation – above national average for referrals.<br>Oxygen prescription – well below national average.<br>Spirometry- below national average. | Changing the way oxygen is prescribed on eCare to make it simpler.<br>Teaching with junior Drs to remind them it needs prescribing.<br>Spirometry – need more staff accredited to undertake it. Escalated as need funding to undertake the course. Then can provide in clinic. Currently only lung function and one respiratory nurse accredited. |

| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| National Comparative Audit of Blood Transfusion programme | Yes | Not available | | |
| National Diabetes Audit – Adults | Yes | Continuous data collection | | |
| National Emergency Laparotomy Audit | Yes | Data for 5th year of NELA (01.12.2018-30.11.2019)<br>63 cases, expected case ascertainment 107, 58.9% (on amber level) | Improved arrival in theatre appropriate to urgency.<br>Consultant surgeon/ anaesthetist presence in theatre.<br>Increased admission to DoCC & unplanned returns to theatre. | Re-examine endpoints of pathway after examination & raise awareness of pathway with trainees.<br>Ongoing action plan with multiple actions being undertaken by the delivery group. Recent presentation at MDT audit afternoon. |
| National Heart Failure Audit | Yes | Continuous data collection.<br>Local level data submission is excellent. Case identification up from 298 – 363 which is nearly a 20% increase in the number of cases, and thereby meets the KPI for the audit. | We are above average for HES data submitted, echo, cardiology inpatient, input from consultant cardiologist, input from specialist, medication use on discharge.<br>We are below average for heart failure nurse follow for HFrEF, but this has substantially risen for 17/18 and we anticipate will rise again in the current year as community HF has come on-line.<br>We are below average for heart failure nurse follow-up for HFrE. | A business plan in progress to improve the cardiac rehabilitation programme. |
| National Joint Registry (NJR) | Yes | 1st April 2019 – 31st March 2020 421 patients – data submitted – 99.05% consent rate. | Audit report 2019 detailed MKUH as an outlier for hips. This was considered infection related. Actions were taken by the team to review their infection rates<br>Trust has been awarded as an NJR quality data provider. | Audit report reviewed in November 2019 where MKUH identified as an outlier for hips/ knees. Action plan implemented address issues included – surgery stopped, ring fenced beds and review of all cases of revision. Monitoring of data continues. |

| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| National Lung Cancer Audit (NLCA) | Yes | Continuous data collection | | Review of the January 2020 published report awaited. |
| National Maternity and Perinatal Audit | Yes | Continuous data collection | Against national average:<br>PPH rate low (1.6%)<br>Induction rate lower (21.3%)<br>C section rate is lower (24.8%)<br>Early elective delivery rate higher (31.3%)<br>Undetected SGA is higher (55.3%)<br>Low spontaneous vaginal delivery rate (62.5%) | Validation of clinical coding for PPH.<br>Advocate normal vaginal delivery & introduce mechanical methods of induction of labour to reduce VBAC rates.<br>Educate staff to think before elective delivery pre-term & ensure robust indications are documented. |
| National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care) | Yes | Continuous data collection | 2019 report not due to be published until July 2020. | |
| National Ophthalmology Audit | No | Not applicable | Unable to participate as participation required further investment to purchase the required software and training package as stipulated by RCOpth. | Reviewed at CAEB. No participation at present as software issue not resolved. |
| Oesophago-gastric Cancer (NAOGC) | Yes | Continuous data collection | | Awaiting national reports before action planning. |
| Paediatric Intensive Care (PICANet) | Yes | Continuous data collection | | Awaiting national reports before action planning. |
| Pain in Children | Yes | Continuous data collection | | Review of paediatric pain pathways by Acute pain team. |
| Perioperative Quality Improvement Programme | Yes | 56 patients were submitted to the audit in 2019 (with completed data sets). | | |
| Procedural Sedation in Adults (care in emergency departments) | Yes | Continuous data collection | Education initiative in place. Data collection and review in process | Education tool developed and rolled out to various areas. |



| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| National Prostate Cancer Audit (NPCA) | Yes | **169**<br>(01/04/2017 – 31/03/2018) submitted in 2019.<br>Data Source: COSD. | Recording PSA results - considerably lower than national data.<br>Membership did not agree with the results. Currently best nationally.<br>Multiparametric - considerably lower than national data. | Previous report in February 2019 had been reviewed and benchmarked against. Short report for prostate biopsies had been reviewed.<br>NPCA full report for 2019 data has been published and reviewed. Outcome of review was shared at CIG and action plan agreed but will need input from Cancer Services Lead.<br><u>Actions</u><br>1. Review of data being submitted<br>Benchmarking audit against NG 131 standards to confirm compliance or undertake Quality Standard review – Prostate Cancer (QS 91). Audit Lead to have a conversation with Cancer Lead to look at this. |
| Sentinel Stroke National Audit programme (SSNAP) | Yes | Continuous data collection | Scanned within 12hrs - 100%<br>Stroke Nurse within 24hrs - 97%<br>OT/Physio assessments within 72hrs - 100%<br>Thrombolysis within 1hr - 83%<br>Transferred to Stroke Unit with 4hrs - 78%<br>At least 90% stay on Stroke Unit - 89% | Review SALT services in community & Trust/ SLA review.<br>Bespoke SALT audit on the Stroke Unit. |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | Yes | 19 adverse events reported | Adverse events reviewed | SHOT is a haemovigilance scheme where we report any adverse events and error related to blood components. It is not an audit tool but a reporting tool |

| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| UK Parkinson's Audit | Yes | Continuous data collection | | No actions from reports. |
| National Comparative Audit of Blood Transfusion programme Use of fresh frozen plasma and Cryoprecipitate in neonates and children | No | | | We do not transfuse enough under 18-year olds, to make a meaningful audit. |
| National Partial mammography Audit NHSBSP | Yes | Data awaiting confirmation | Audit undertaken by radiology lead and results disseminated. | Review and action planning from Breast team. |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit programme (Pulmonary Rehabilitation work stream) | No | N/A | N/A | Registered for 2020 audit |
| National audit of small bowel obstruction (SBO) | Yes | According to the NCEPOD in next table – 2 cases | NCEPOD requested information - provided | National report for SBO was shared with the surgeons in January 2020. Awaiting review of recommendations. |
| National Diabetes Foot Care Audit | | | We have nearly 13K people with diabetes in MK and the care for the vast majority of these is provided within the community.<br>We have a community hub at Willen, with 5 diabetes specialist nurses and a 0.5WTE consultant, fulfilled by 2 consultants.<br>We work with our primary care colleagues through-<br>Virtual clinics<br>Joint clinics<br>Assessment clinics<br>Annual diabetes conference<br>We have an integrated triage system for all but emergency referrals (RMS), triaged by consultants. | Created an annual diabetes conference.<br>Structured education for patients-DAFNE for type 1 DM and DESMOND for type 2 DM.<br>NDA data shows that we perform better than NHS England average for type 1 and type 2 treatment targets. |

| Name of Audit | Did MKUHFT participate | Number of cases submitted | Findings & recommendations – Local & National reports | Changes & actions |
|---|---|---|---|---|
| National Acute Kidney Injury Programme | Yes | ONGOING | No data available yet | Acute Kidney injury prevention education in development. |
| National care at end of life | Yes | 2019 data | Examples of poor communication highlighted<br>Late recognition of dying<br>Lack of Palliative Care Team at the weekend | Trust investing in Sage and thyme course and training more facilitators. course to be available to all following the training of more trainers.<br>Teaching at grand round/ mand training/ essential skills (now called something else). Teaching GSF at board rounds.<br>7 day working introduced. |
| National Asthma and COPD Audit Programme (NACAP) | Yes | | Delay in COPD patients or proportion of COPD patients being reviewed by specialist Respiratory staff.<br>Higher COPD readmission rate compared to National Average.<br>Lower rates of prescription of smoking cessation pharmacotherapy. | Additional Respiratory ANP recruited to support COPD patients with early assessment and supported discharge.<br>Reconfiguration of Community COPD Pathway involving SCAS, CNWL Rapid Response, Respiratory ANP and Community Respiratory Clinics to work in a closer and coordinated relationship to prevent readmissions.<br>Working with the Smoking Cessation Service to train extra nursing staff in identifying smokers and prescribing smoking cessation therapy. |

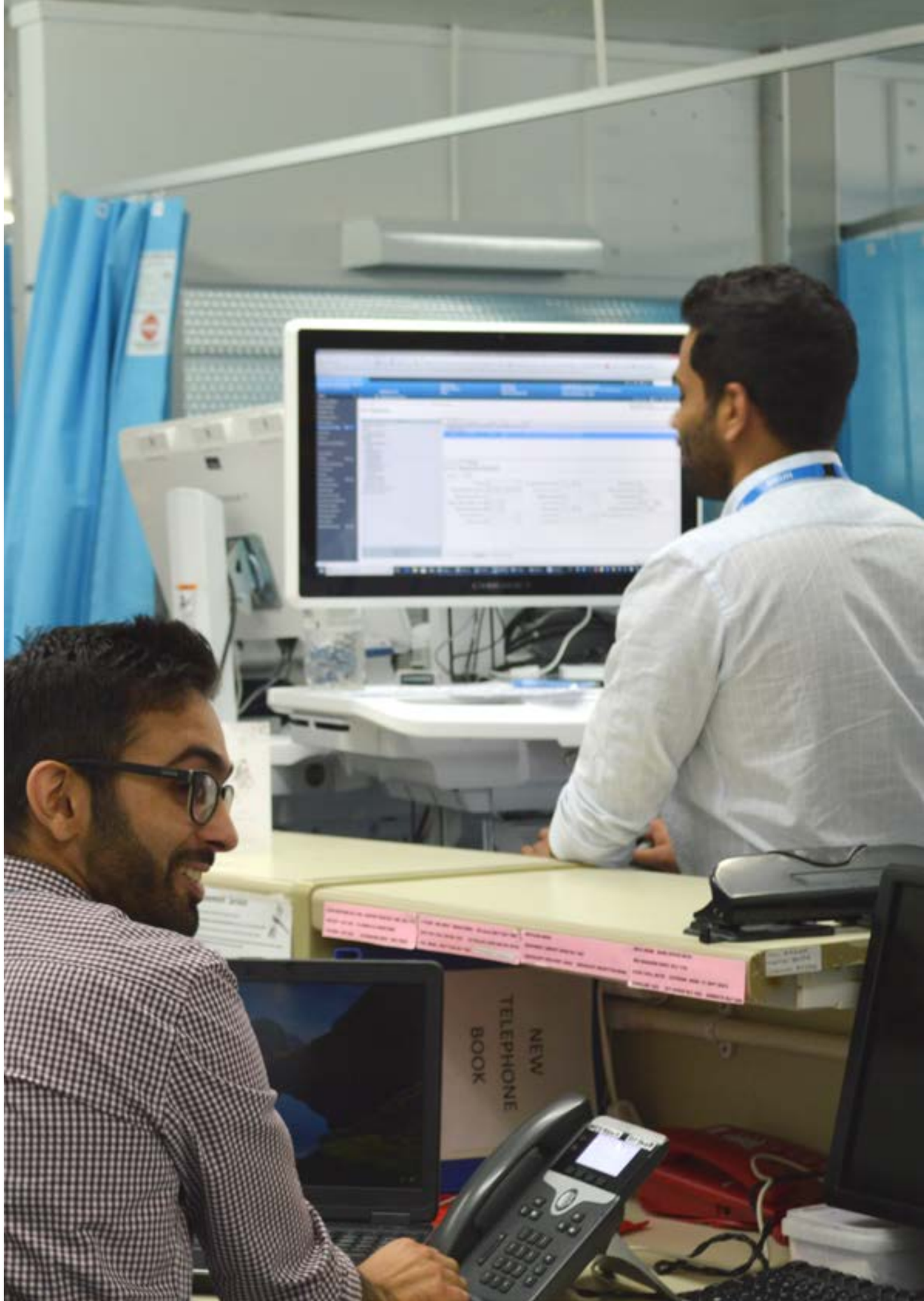
During 2019/20 hospitals were eligible to enter data in up to four National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies. The Trust was exempt from participating in two of these. The table below summarises those studies that were applicable to and participated in by MKUH.

| National Confidential Enquiry into Patient Outcome and Death Study Eligible 2018/19 | Participated | Cases Submitted |
|---|---|---|
| Dysphagia (please note this study is still open and the figures have not been finalised) | Yes | 3/4 |
| Out-of-hospital cardiac arrest (OHCA) (please note this study is still open and the figures have not been finalised) | Yes | 0 |
| Acute Bowel Obstruction (please note this study is still open and the figures have not been finalised) | Yes | 2/4 |
| Long term ventilation | N/A | 0 |
| Number of cases submitted were the number requested by NCEPOD | | |

**HQIP National Clinical Audit List**
**The National Clinical Audit Programme**

- Falls and Fragility Fracture Audit (includes the Hip Fracture Database) (FFFAP)
- Heart: Coronary angioplasty (percutaneous coronary interventions)
- Heart: Myocardial Ischaemia National Audit Project (MINAP)
- Heart: National Adult Cardiac Surgery Audit
- Heart: National Congenital Heart Disease Audit
- Heart: National Heart Failure Audit
- Heart: National Heart Rhythm Management Audit
- National Adult Diabetes Audit (NDA)
- National Asthma and COPD Audit Programme (NACAP)
- National Audit of Breast Cancer in Older Patients (NABCOP)
- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Bowel Cancer Audit (NBoCA)
- National Cardiac Audit Programme (NCAP)
- National Clinical Audit of Anxiety and Depression (NCAAD)
- National Clinical Audit of Psychosis (NCAP)
- National Early Inflammatory Arthritis Audit (NEIAA)
- National Emergency Laparotomy Audit (NELA)
- National Epilepsy 12 Audit
- National Lung Cancer Audit (NLCA)
- National Maternity and Perinatal Audit (NMPA)
- National Neonatal Audit Programme (NNAP)
- National Oesophago-Gastric Cancer Audit (NOGCA)
- National Ophthalmology Audit (NOD)
- National Paediatric Diabetes Audit (NPDA)
- National Prostate Cancer Audit (NPCA)
- National Vascular Registry (NVR)
- Paediatric Intensive Care Audit Network (PICANet)
- Sentinel Stroke National Audit Programme (SSNAP)





# 2.5 Participation in Clinical Research

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

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

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

An increasing number of patients receiving relevant health services provided or sub-contracted by MKUH in 2019/20 were recruited to participate in National Institute of Health Research (NIHR) studies approved by a research ethics committee. In 2019/20 over 4,500 patients were recruited to 54 studies in the Trust.

The Research and Development department received over £750,000 for 2019/20 to deliver NIHR portfolio research.

This year the team has continued to grow to support the increasing research activity across the Trust. The budget award for 2020/21 is still to be finalised, however it is unlikely there will be an increase in funding for this financial year, which may require some new ways of delivering research to ensure that our patients continue to receive a first class service.

The department has supported and delivered training of new research staff at MKUH and through network supported training programmes. e.g. Good Clinical Practice (GCP) training, Principle Investigator essentials training, and the industry workshop. These courses are open to our staff and other research staff across the Thames Valley and South Midlands Clinical Research Network. Several of our clinicians have been successful in securing 'green shoots' funding from the NIHR, Thames Valley and South Midlands. This is for new researchers to enable dedicated research time as Principal Investigators/research activity and deliver against our wide portfolio of studies, as well as developing new research areas. Funding will be provided for one year.

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

Our research activity has contributed to the evidence base for healthcare practice and delivery, and in the last year (2019/20) a number of publications have resulted from our involvement in research, demonstrating our commitment to improve patient outcomes and experience across the NHS.

From 2019-20, the participant experience survey (PRES) has been made a Higher Level Objective by the Department of Health and Social Care (DHSC) in recognition of the importance of participant experience of feedback to both the DHSC and the NIHR. It is carried out to help continually improve the experience of taking part in health research and gives participants chance to feedback on what went well and what could be improved. This year MKUH received 132 responses from patients and the majority of patients surveyed had a positive experience of taking part in research and 104 participants agreed/strongly agreed that they would take part in another research study.


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

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

# 2.6 Goals agreed with Commissioners (CQUIN)

**A proportion of Milton Keynes University Hospital NHS Foundation Trust income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between Milton Keynes University Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.**

Further details of the agreed goals for 2019/20 are listed below.

**National Goals**

| 2019/20 CQUINs for Milton Keynes University Hospital NHS Foundation Trust | | | |
|---|---|---|---|
| **Indicator** | **Indicator Name** | **High level detail** | **Expected delivery 2019/20** |
| CCG2 | Improving the uptake of flu vaccinations for front line staff within Providers | Achieving an uptake of flu vaccinations by frontline clinical staff of 80%. | This CQUIN has been achieved in full. The Trust achieved a total frontline flu vaccination uptake of 81%. |
| CCG7 | Three high impact actions to prevent Hospital Falls | Admitted patients aged over 65 years, with length of stay at least 48 hours where all three specified falls prevention actions are met and recorded:<br>1. Lying and standing blood pressure recorded at least once.<br>2. No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British National Formulary defined hypnotics and anxiolytics and antipsychotics).<br>3. Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit. | This CQUIN has achieved 85% of the CQUIN (as at 31 December 2019). Collection of fourth quarter data was suspended due to Covid-19. |
| CCG11a | SDEC – Pulmonary Embolus | Achieving 75% of patients with confirmed pulmonary embolus being managed in a same day setting where clinically appropriate. | This CQUIN has been achieved in full. |
| CCG11b | SDEC – Tachycardia with Atrial Fibrillation | Achieving 75% of patients with confirmed atrial fibrillation being managed in a same day setting where clinically appropriate | This CQUIN has been achieved in full. |
| CCG11c | SDEC – Community Acquired Pneumonia | Patients with or confirmed Community Acquired Pneumonia should be managed in a same day setting where clinically appropriate. | This CQUIN has been achieved in full. |



# 2.7 Care Quality Commission (CQC) registration and compliance

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

- Urgent and emergency services
- Medical care
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

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

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

## 2.7.1 Review of Compliance of Essential Standards of Quality and Safety

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

There were a number of areas that were not inspected – these were critical care, outpatients, diagnostic imaging, children and young people's services and end of life care. These areas retain their previous ratings awarded in 2014/16were not inspected and so their ratings remain from the previous inspection in October 2016. All of these services were rated as "Good" at that time.


## 2.7.2 Overall Ratings for Milton Keynes University Hospital:

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

## 2.7.3 Key findings from the report:

**Are services safe?**

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

**Are services effective?**

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

**Are services caring?**

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

**Are services responsive?**

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

**Are services well-led?**

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

### 2.7.4 Areas of Outstanding practice

## Outstanding practice

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

**In maternity:**

Two new smartphone apps for pregnant women had been introduced, which enabled women to take more ownership and management of their care on a day to day basis.

In December 2018 the Warm Baby Bundle red hat initiative was rolled out across the maternity service for babies at risk of hypothermia and in extra need of skin-to-skin contacts.

An online patient portal was introduced to empower patients to manage their own health care appointments.

In January 2019, pregnant women who had uncomplicated pregnancy were offered the option of an outpatient induction of labour.

**In medical care:**

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met those needs, was accessible and promoted equality.

The wards ensured that patients were given activities and welcome packs. Staff really promoted independence, enabling patients to eat dinner at tables, take part in group activities and ensure they were ready for discharge.

The service was supported with social workers and dedicated ward discharge teams, where there was effective communication and the discharge process was discussed at parts of the patient's journey.

### 2.7.5 Areas of compliance or enforcements actions

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

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

**In urgent and emergency care:**

- The service must ensure that immediate life support and paediatric immediate life support training compliance is in line with Trust targets. *This has now been done.*
- The service must ensure that staff are complaint with hand hygiene and personal protective equipment guidelines. *Staff received additional training to ensure compliance.*
- The trust must ensure that all emergency equipment checks are done in line with Trust policy and that there is a system in place for ensuring this is completed. *A system has been developed and implemented.*
- The service must ensure that all patients receive relevant risk assessments. *This was implemented with immediate effect, with additional training given to staff performing falls, pressure ulcer and nutritional risk assessments.*
- The service must ensure there are robust action plans to address areas of non-compliance to local and national audits. *This has been implemented to ensure compliance.*

**In relation to surgery core service:**

- The Trust must ensure that basic life support training for all staff and safeguarding training compliance for medical staff is in line with targets. *A robust plan of action was implemented to ensure compliance.*
- Ensure that controlled drugs are checked, and accurate records maintained. *This has been scrupulously enforced and maintained.*
- Ensure that staff are compliant with personal protective equipment, safe handling of dirty instrumentation and 'bare below the elbows' guidelines. *This is robustly enforced.*



# 2.8 Data Quality

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

Some of the notable actions include:

1. The Data Quality Compliance Board (DQCB) is now embedded as a key governance committee which continues to review the data quality across the Trust. The DQCB continues to receive audit and compliance reports and additional reports highlighting the data quality underpinning key performance indicators enabling the triangulation of poor data quality and oversee actions plans to address them.
2. The establishment of a new dedicated Systems/Training team with a remit to provide expert advice and guidance on matters of system data quality and a dedicated, ongoing data quality training programme. The Systems/Training team receive feedback from compliance audit reports and areas of poor data quality otherwise identified and work with the Divisions to identify and training needs and support staff with system use. In addition, this team continues to develop supporting documentation and training resources to reduce the risks of poor data quality through poor data entry.
3. Updating the Patient Access Policy to reflect the national NHS Improvement Model Access Policy and strengthening the local guidance arrangements on long waiting (>30 weeks) patients. This includes better controls on the managing patients on inpatient waiting lists and communication to the patient's GP. These new updates are designed to support the existing clinical governance arrangements in place for patient review.
4. Fully developed system assurance reports covering key Trust systems used in support of patient care. Where areas of poor practice have been identified which have contributed to poor data quality, Executive Directors have developed action plans to address these shortcomings. The development of action plans and monitoring the delivery of actions is undertaken by the DQCB. The Trust has committed to expanding the delivery of system assurance reports to cover all Trust systems as part of ongoing improvements to data quality in the next financial year.
5. The centralisation of the administrative functions around the elective processes for both admitted and outpatient care. The purpose is to achieve a consistent approach and to ensure that the controls around data quality, particularly those in respect of the 18-week Referral to Treatment target are effective.

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

The Trust submitted data records during 2018/19 to the Secondary Uses Services (SUS) for inclusion in the Hospital Episode Statistics (HES). It has maintained data completeness over the national average across the activity areas of inpatients, outpatients and A&E for ethnicity and both outpatients and A&E for NHS number completeness. The NHS number completeness for admitted care is slightly below average but this is explained by an increased number of admissions but a similar number of records missing an NHS number.

The table below provides further information on the data completeness for national indicators NHS number and ethnicity*, with national averages.

| Data item | Admitted | Outpatients | A&E |
|---|---|---|---|
| Completeness NHS number | 99.1 (99.4) | 99.6 (99.6) | 97.7 (97.5) |
| Completeness ethnicity | 99.2 (96.2) | 98.8 (94.1) | 98.6 (93.8) |

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

# 2.9 Qualitative information on deaths (whilst maintaining patient anonymity)

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

The National Medical Examiner system forms part of the NHS Patient Safety Strategy in England. Introducing Medical Examiners is a vital step in the drive to improve patient safety in the NHS. The Trust has successfully implemented Medical Examiners since May 2019 and now has a team of 10 Medical Examiners. This includes Hospital Consultants from a wide range of specialties to provide a breadth of clinical experience and expertise and Senior General Practitioners.

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

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

**Previous classification for assessing death avoidability 2019/2020.**

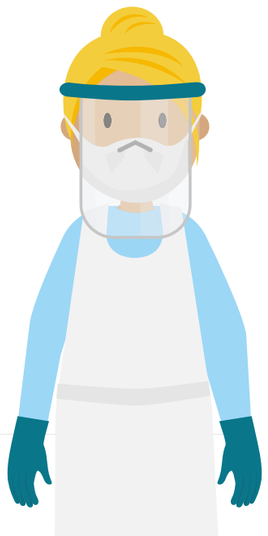
Judged as potentially 'avoidable' – using the current system of classification within the Trust this includes 'suboptimal care where different management MIGHT have changed outcome and 'suboptimal care where different management WOULD have changed outcome'.

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'.

**New process for assessing death avoidability 2020/2021.**

If a death is deemed avoidable a 2nd Structured Judgement Review is carried out at which point this will be graded to judge avoidability of death score (Score of 3 or less). This form will conclude with key learning messages from the case and actions to be followed.

- Score 1 Definitely avoidable
- Score 2 Strong evidence of avoidability
- Score 3 Probably avoidable (more than 50:50)
- Score 4 Possibly avoidable but not very likely (less than 50:50)
- Score 5 Slight evidence of avoidability
- Score 6 Definitely not avoidable.






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

**Investigations of Deaths 2019/2020**

| | Q1 Apr-Jun 2019/20 | Q2 Jul-Sep | Q3 Oct-Dec | Q4 Jan-Mar |
|---|---|---|---|---|
| No. of deaths | 298 | 261 | 247 | 302 |
| No. of deaths reviewed by Medical Examiner† | 199 (67%) | 100% | 100% | 100% |
| No. of investigations (% of total) | 152 (51%) | 58 (22%) | 31 (13%) | 16 (5%)* |
| No of Coroner Referrals (%of total) | 32.5% | 38.3% | 25.9% | 18.5% |
| No. of deaths with Care Quality concerns (%) | 2 | 1 | 0 | 0 |
| No. of potentially avoidable deaths (%) | 1 | 0 | 0 | 0 |

*† All deaths reviewed by Medical Examiner Scrutiny process.*

** Q1 data are provisional and are still subject to further modification (as formal review processes occur within the Trust's clinical divisions.*

Individual cases where care quality concerns are identified are discussed at the mortality review group, and information / learning is shared with Trust Board and its sub-committees. During 2020/21, medical examiners will work to increase the proportion of cases in which they identify potential care quality concerns in order to feed into the structured judgement review process.

# 2.10 Seven Day Services

**The 7 Day Service (7DS) standards have been defined by NHS England and focus upon the care provided to patients admitted to hospital on an emergency basis. The ten standards are divided into four priority standards and six others. It is expected that organisations are compliant with the priority standards by April 2020. Work on the 7DS standards at MKUH is led by the Medical Director's Office.**

Progress against the four priority standards is now being measured through data arising from the weekly audit of 60 randomly selected patients discharged following an emergency admission in the prior week. Performance is now reported externally using a 'Board Assurance' framework. Of note, documentation of direct consultant involvement is measured (which may not record 100% of such involvement).

Over the course of 2019/20, the Trust made progress against the delivery of the priority 7-day services standards. Specific progress was made as follows:

**Standard 2 –** improvement to 84% of patients with documented consultant review within 14 hours of admission (90% standard not achieved).

**Standard 5 –** timely on-site access to diagnostics (achieved).

**Standard 6 –** formal arrangements in relation to networked urgent procedures (achieved).

**Standard 8 –** improvement to 67% of patients with documented daily consultant review (90% standard not achieved).

Seven Day Services (7DS) performance was presented at Public Board at the appropriate points throughout 2019/20.

Work to improve attainment of standards 2 and 8 continued into 2020/21 and – in the context of the Covid-19 pandemic – standards 2 and 8 were met with emergency medical staffing rosters.


# 2.11 Report by the Guardian of Safe Working Hours

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

The contract was then applied in a phased approach to different specialities and grades until August 2017 when the vast majority of doctors had moved over to the new contract.

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

During the financial year 1st April 2019 – 18th March 2020 the following exceptions have been reported:

| Type | Accident and Emergency | Acute Medicine | Anaesthetics | Diabetes & Endocrinology | Gastroenterology | General Medicine | General Surgery | Haematology | Obstetrics and Gynaecology | Paediatrics | Respiratory Medicine | Urology | Otolaryngology Otolaryngology | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Educational | | 6 | | | | | 7 | | 3 | | | | 1 | 17 |
| Hours | 12 | 77 | 2 | 8 | 28 | | 42 | 2 | 22 | 5 | 42 | 11 | 3 | 254 |
| Pattern | | 3 | | | | | 2 | | 2 | | 1 | 2 | | 10 |
| Service Support | | 2 | | | | 1 | 6 | | 1 | | | | 1 | 11 |
| **Grand Total** | **12** | **88** | **2** | **8** | **28** | **1** | **57** | **2** | **28** | **5** | **43** | **13** | **5** | **292** |

The majority of exception reports have related to hours of work within Acute Medicine and General Surgery. These two departments host the largest number of doctors in training, including Foundation Year 1 doctors. Exception reporting continues to highlight issues to include in service design. Other elements of the new contract, including the junior doctors' forum, are in place.

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

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

These include:

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

Of the routes for speaking over concerns of patient safety, quality of care or bullying, we encourage staff members to use the Freedom to Speak Guardian. We have Freedom to Speak Up champions who act as signposts to the Guardian. At the beginning of March 2020 MKUH recruited additional Freedom to Speak Up Champions so will have a lead Guardian plus five others. The lead Guardian will then lead the recruitment of further Champions to boost the importance, accessibility and visibility of the role.

There is clear support from the Chief Executive Officer and Board lead for Freedom to Speak Up. The Trust has a comprehensive and accessible Speaking Up Policy which supports how colleagues can raise concerns with the FTSU Guardian/Ambassadors and ensures that anonymity is afforded to those individuals as a matter of course to ensure that they are protected from detrimental behaviour as a result of having raised a concern. In addition to the policy, there is Trust-wide signage outlining the names and contact details of the FTSU Guardians and Ambassadors (telephone numbers and email addresses). Feedback is given directly to colleagues who raise a concern and, in-turn, feedback received from those making disclosures indicates that the facility to raise their concerns and have them heard, often for the first time, had been beneficial in its own right.

There has been a drop in reporting to the Guardian; there were no contacts during Q3, (Oct-Dec 2019). The Lead Guardian is using the regional Guardians group to seek ideas as to whether other Trusts have experienced similar. Staff who have spoken up in the past have not reported any detriment to them for doing so. During the same period, there were 246 contacts made to the Trust's informal and confidential P2P (Peer to Peer) listening service.

The current Lead Guardian has had one approach in later 2019 asking for the delivery of information about Freedom to Speak up to a group of junior doctors.

The lead Guardian is due to address the latest intake of Medical students, to encourage them to use Freedom to Speak Up as they progress through training and into their future careers. MKUH is about to introduce Freedom to Speak Up into mandatory training for staff.

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




# 2.13 Reporting against core indicators

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

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

a) The national average for the same; and

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

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

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

**SHMI Table**

| 12. Domain of Quality | Level | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|---|
| Summary Hospital-level Mortality Indicator (SHMI) | **MKUHFT** | 1.04 (Band 2) | 1.04 (Band 2) | 0.99 (Band 2) | 1.05 (Band 2) | 1.09 (Band 2) |
| | National | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| | Other Trusts Low/High | *It is not appropriate to rank trusts by SHMI* | | | | |

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

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

| Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **23. Domain of Quality** | **Level** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** |
| Patients admitted to hospital who were risk assessed for venous thrombo-embolism (Q3 results for each year) | **MKUHFT** | 96.0% | 96.0% | 95.1% | 85.6% | 76.9% | 96.8% | 98.0% |
| | National | 96.0% | 96.1% | 95.6% | 95.8% | 95.4% | 95.7% | 95.3% |
| | Other Trusts Low/High | 80% / 100% | 90% / 100% | 79% / 100% | 80% / 100% | 76% / 100% | 55% / 100% | 72% / 100% |
| | National (Acute) | 8.7 (0.07) | 37.1 (0.19) | | | | | |
| | Other Trusts Low/High | 1.2 (0) / 15.5 (0.37) | 3.6 (0.02)/ 82.2(1.53) | | | | | |

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

During 2019/20 the Trust made effective use of eCare, its electronic patient record system to simplify the data collection process

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

| **24. Domain of Quality** | **Level** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** |
|---|---|---|---|---|---|---|---|---|
| Rate of C. difficile infection (per 100,000 bed days) | **MKUHFT** | 22.5 | 23.4 | 10.13 | 6.0 | 7.1 | 8.6 | 5.1 |
| | National | 14.7 | 15.0 | 14.9 | 13.2 | 13.6 | 12.2 | 13.6 |
| | Other Trusts Low/High | 0/37.1 | 0/62.6 | 0/67.2 | 0/82.6 | 0/90.4 | 0/79.8 | 1/51.0 |

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

Antimicrobial resistance continues to play an important role in driving the current numbers of *Clostridium difficile* and the emergence of new types. *Clostridium difficile* although greatly reduced in terms of the numbers of cases seen at the MKUH, should still be recognised as a major cause of healthcare antibiotic-associated diarrhoea.

Antimicrobials used for treating every kind of infection may potentially promote *C. difficile* infection (CDI). After antibiotic therapy, the protective intestinal microbiota is disrupted allowing ingested or resident *C. difficil*e to colonise the gastrointestinal tract and infect the host. Antibiotic resistance enables *C. difficile* to grow in the presence of drugs, so strains resistant to multiple agents may have a selective advantage.

The MKUH CDI multidisciplinary team closely monitor therapy in support of tempering the inflammatory response preventing severe infection and resultant poor outcome.

Primary risk factors for the development of CDI include advanced age (greater than 65 years), antimicrobial use, severe illness, and hospitalisation. Secondary factors that also increase the risk include gastric acid suppression (with proton pump inhibitors or histamine-2 receptor antagonists), gastrointestinal procedures, chemotherapy, residence at a long-term care facility, inflammatory bowel disease, and immunosuppression. Furthermore, in those infected with C. difficile, low levels of vitamin D are now suspected to be an independent predictor of poor outcome and are associated with higher recurrence.

The definition of hospital associated CDI changed from April 2019 to 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.)

As of March 23, 2020, 13 cases of CDI were reported as attributed to MKUH. Patients had an age range of 44 – 93 years, with a fairly equal split between the genders.

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.

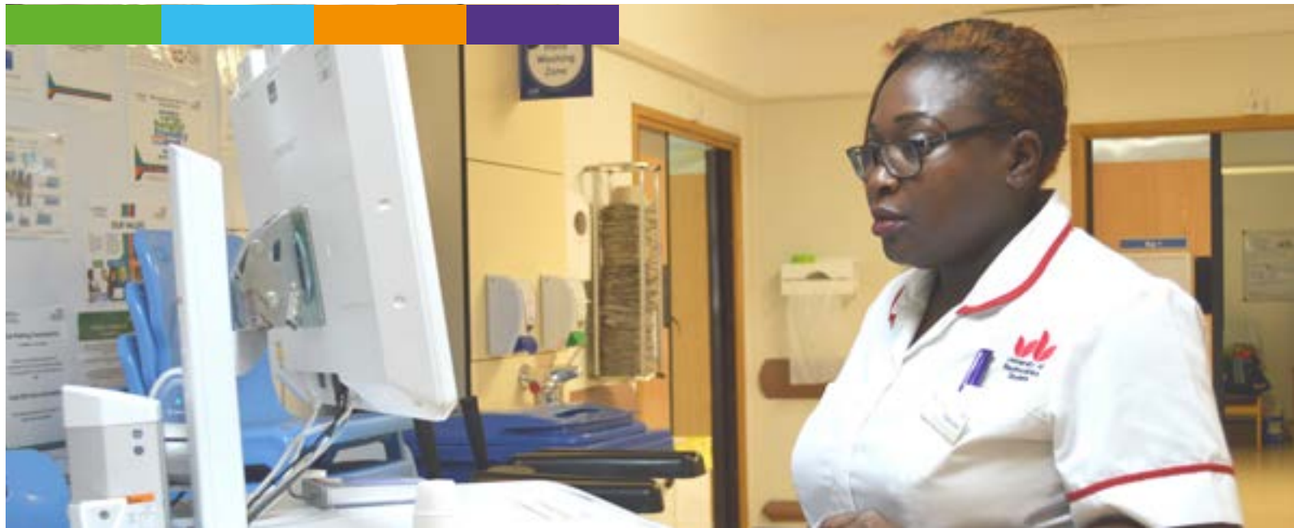
Due to the impact of Covid-19 national data for 2019/20 has not yet been published (as of November 2020) by NHS Digital.

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

There were 8357 Patient Safety incidents reported last financial year. This equates to a reporting rate of 51.64 incidents per 1,000 bed days. Of these 26 (0.31%) were categorised as Major/Catastrophic.

The Trust reports patient safety incidents onto the National Reporting & Learning System (NRLS). NHS England uses the data to monitor incident trends NHS-wide and they produce a bi-annual report comparing the Trust to other acute organisations. The reporting rate of all incidents has increased, but the Trust continues to be one of the lowest reporting organisations. NRLS latest available data reports the percentage of incidents reported by the Trust as either none or low harm make up 99% of the incidents reported compared to 98.9% reported on average by acute organisations, and the percentage of incidents reported as moderate at 1% less than that of the average, and the percentage of severe or death incidents 0.1% lower than the average. Actions have been put in place to increase awareness of the importance of reporting incidents and to encourage the report of incidents including event in the tent focusing on patient safety, revised mandatory and refresher training and an incident awareness campaign.

Milton Keynes University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: the data sets are nationally mandated and internal data validation processes are in place prior to submission. Data for 2019/20 has not yet been published locally or nationally by NHS Digital (as at November 2020).



**Responsiveness to inpatient needs**

The Trust's patient experience team continues to work with the clinical teams with a view to improving patients' experience of receiving care. There are a number of channels by which patients are able to provide feedback on the care that they have received, and the Trust has responded proactively to these emerging messages.

In November 2019, the Board of Directors approved a new patient experience strategy which is now being implemented. Due to the impact of Covid-19 in February and March 2020, some of the usual channels of feedback were nationally halted including the Friends and Family Test.

| Domain 4: Ensuring that people have a positive experience of care | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **20. Domain of Quality** | **Level** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** |
| Respon-siveness to inpatients' personal needs | **MKUHFT** | 65.3% | 65.4% | | 64.6% | 63.1% | 64.5% | Update delayed due to pandemic |
| | National | 68.7% | 68.9% | 69.6% | 68.1% | 68.6% | 67.2% | |
| | Other Trusts Low/High | 54.4% / 84.2% | 59.1 / 86.1% | 58.9% / 86.2% | 60.0% / 85.2% | 60.5% / 85.0% | 58.9% / 85.0% | |

| Domain 4: Ensuring that people have a positive experience of care | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **20. Domain of Quality** | **Level** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** |
| Staff who would recommend the trust to their family or friends | **MKUHFT** | 59% | 61% | 64% | 69% | 66% | 68% | Data delayed due to pandemic |
| | National | 66% | 59% | 69% | 65% | 70% | 70% | |
| | Other Trusts Low/High | 40% / 94% | 35% / 84% | 46% / 89% | 48% / 91% | 47% / 89% | 41% / 90% | |

| | **Level** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** |
|---|---|---|---|---|---|---|---|---|
| Patients who would recommend the trust to their family or friends (Inpatient FFT - February in each year available) | **MKUHFT** | *Not a comparable metho-dology (FFT Score)* | 96% | 95% | 96% | 97% | 96% | 96% |
| | National | | 95% | 96% | 96% | 96% | 96% | 96% |
| | Other Trusts Low/High | | 82% / 100% | 74% / 100% | 76% / 100% | 82% / 100% | 76% / 100% | 82% / 100% |

# 3. Other Information



# 3.1 Patient Experience

### 3.1.1 Complaint response times

The total number of complaints received for 2019/20 at the time of reporting totalled 1227. When compared to 2018/19 this amounts to a reduction of 13.3% (2018/19 n= 1415).

All complaints are triaged by severity upon receipt. The number of complaints received by severity for 2019/20 is detailed below:

| | |
|---|---|
| **Red - Severe harm** | 2 |
| **Amber - Moderate Harm** | 330 |
| **Yellow - Low Harm** | 863 |
| **Green - No Harm** | 32 |

In percentage terms the number of no and low harm complaints amounts to 73% (73% 2018/19) of total complaints received.

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

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

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

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

To ensure that complainants are provided with a timely response to their complaint and investigations are undertaken in a timely manner, the Trust has set its own internal timescales for dealing with complaints and these are set a; 60 working days for severe harm (red), 30 working days for moderate harm (amber) complaints, and 15 working days for no and low harm (yellow and green) or within timescales agreed with the complainant. Divisional compliance with these timescales is monitored and reported through the Trust's scorecard which is reported to the Board monthly. The target for responding to complaints in the timescales agreed with the complainant is set at 90%. In the year to date, the Trust has achieved an average monthly performance of 90.6%.

The achievement in performance in relation to reaching the target set has occurred as a result of a robust escalation process being in place. This ensures, at an early stage, that late investigation responses are highlighted to the senior divisional team and the Executive Directors, if necessary. A weekly RAG rated report is shared with the divisions through each division's senior team and weekly meetings are held with the complaints office and the division to chase any outstanding investigation requests. Where escalation has not been successful each individual case is escalated to the appropriate Executive Director with a request for their assistance in obtaining the overdue report.

It has been recognised that, generally, national benchmarking in respect of the total number of complaints received, is currently not possible due to the different services and populations that each hospital serves.

Benchmarking is available, however, for those complaints that are received in **writing.** This information is available through a return, undertaken quarterly, known as the KO41a return. Information from each Trust, in relation to written complaints only, is collated and shared with the Department of Health. This information is available retrospectively and from this we can ascertain the number of written complaints that neighbouring Trusts deal with, as detailed below.

| TRUST | Q1- Written complaints | Q2 – Written complaints | Q3 – Written complaints |
|---|---|---|---|
| MKUH | 199 | 228 | 169 |
| Northampton Hospital | 119 | 171 | 136 |
| Luton and Dunstable Hospital | 112 | 108 | 129 |
| Buckinghamshire Health Care Trust | 193 | 178 | 145 |
| Bedford Hospital | 52 | 43 | 50 |

The number of complaints MKUH receive is in part due to the increased number of contacts to the PALS service. Since July 2017, PALS has been based in the main entrance of the hospital and is therefore highly visible for all patients and visitors with ease of access either in person, by email, telephone or text. The number of contacts to PALS has increased since patients have been made aware of its presence when leaving the hospital through the main entrance.

Also, many people access the service due to their prior experience of PALS. Throughout the organisation staff training is undertaken regarding the remit of PALS and how patients can contact the service if they have any issues or need advice and information. This has resulted in patients and their families being correctly signposted to the PALS service when they have not been able to resolve an issue locally with the ward or department. The PALS team have also visited wards during this year to promote the PALS service by making people aware of the service and providing leaflets for patients and visitors.

# 3.2 Patient Safety

### 3.2.1 Duty of Candour

The Trust looks to proactively be open and honest in line with the Duty of Candour requirements and looks to advise/include patients and/or next of kin in investigations. The Trust incident reporting policy outlines Duty of Candour (DOC) compliance in line with national regulatory and standard contract requirements. For patient safety incidents reported as a moderate grading or above an initial apology is required where it is recognised that there have been care/service delivery omissions that have resulted in significant harm, followed by a formal written apology. This is tracked on the Trust's Datix system where a dashboard reflects live compliance with both the first & second stages. DOC data is included as a Trust KPI and reported at corporate governance meetings.

The Trust's Head of Risk & Clinical Governance has lead responsibility with delegated responsibilities within the Risk Management Team for day to day management. All DOC letters are approved by the Head of Risk & Clinical Governance and her details given as a point of contact if required. For all serious incidents reported on STEIS a formal DOC apology letter is sent which includes offering the patient/relatives the opportunity to be involved in the investigation and a further letter sent on completion of the investigation. Meetings with patients/relatives have been helpful, with fact to face communications enabling an empathetic apology and discussions on the key learning being taken forward.

DOC letters are further included in root cause analysis (RCA) action plans which are tracked by the Trust's commissioners until all evidence is received to show completed, from an assurance perspective. From March 2017 a covering letter was included in the Trust bereavement packs informing that all deaths across the organisation are investigated and if relatives had concerns regarding care or treatment, we would look to include this in the Trust mortality reviews and feedback the findings. This process has received positive feedback and helped to give reassurances that as an organisation we look to actively learn from incidents and put in place mitigation against other similar incidents in the future. In 2019 this has evolved further with the introduction of Medical Examiners and their communications with families.

The 2018/19 and 2019/20 Service Quality Performance Reports report full compliance based on the Datix DOC dashboard live data and is provided at month end (last working day) against a performance denominator of 0.

### 3.2.2 Preventing Future Death (PFD) reports

The Trust received 2 PFDs from HM Coroner in the year 2019 – 2020 which related to:

- A concern that the problems encountered in the Emergency Department (ED) on 4th June 2019 were mainly brought about by staff shortages. HM Coroner was told that staff shortages occur on a daily basis and HM Coroner believed that as a result lives of this citizens of Milton Keynes are being put at risk and the problem should be addressed as a matter of urgency.

The Trust's response outlined ensure that staffing levels in the ED are safe – both in general terms and shift-by-shift and gave assurances that we have a good understanding of our staffing levels in the ED, and data that evidenced the position. We have invested heavily in clinical staffing levels over the past six years and have measures in place day-to-day in order to ensure that the risk associated with any sub-optimal staffing numbers is spread appropriately across the organisation such that 'sub-optimal' does not equate to 'unsafe'.

- A concern that staff were unaware of certain facts relating to the patient at the time that they were dealing with him and making decisions relating to his care, and yet the information was recorded in the electronic notes and records. It appeared to HM Coroner that staff are having difficulty accessing vital information that should be clearly available to them. HM Coroner asked that the Trust carry out a review of the notes system to see whether or not it is being used correctly, whether staff members have been adequately trained with regard to its use and whether changes should be made as to how information is recorded and retrieved. Unless the system is working effectively, HM Coroner anticipates that further lives will be put at risk.

The Trust's response outlined that when the eCare system was introduced we ensured the system was introduced safely, and with the minimum of disruption to patients and patient care, we undertook an extensive programme of staff training in the lead up to going live across hospital inpatient areas (including the ED and Maternity). This programme included individual and team training; dedicated staff to support wards and departments on the use of the system after go-live; training for all temporary staff; and training materials, including videos, as well as individual and team support remaining readily available. The Trust also appointed a Chief Clinical Information Officer (a consultant vascular surgeon) and a Chief Nursing Information Officer (an experienced senior nurse), to ensure appropriate clinical oversight and input into all aspects of eCare – from its introduction to ongoing training and future developments. We have a robust governance process and structure in place to oversee the development, implementation and continued performance of eCare, including staff training and use of the system. This structure reports to a main board (the Health Informatics Programme Board) which is chaired by the Trust's Chief Executive. This board has oversight of risks and issues and works to ensure that these are mitigated and managed appropriately.

### 3.2.3 Serious incidents (SIs) & never events

The Trust did not report any never events in the year 2019 – 2020.

The Trust reported 66 SIs in the year which can be broken down as follows:

| SI Category | Number of incidents |
|---|---|
| Pressure Ulcer | 17 |
| Delayed Diagnosis | 15 |
| Sub-optimal care of the deteriorating patient | 9 |
| Drug Incident (general) | 7 |
| Other | 4 |
| Slips, Trips, Falls | 4 |
| Maternity Service - Unexpected admission to NICU | 3 |
| Maternity Service | 2 |
| Maternity Service - Intrauterine Death | 1 |
| Medical Equipment Failure | 1 |
| Safeguarding Vulnerable Adult | 1 |
| Unit Closure | 1 |
| Wrong Site Surgery | 1 |
| **Total** | **66** |

The Trust's Serious Incident Review Group (SIRG) consisting of staff from across the Multi-Disciplinary Team, reviews all incidents reported on Datix at moderate and above, commissioning deep dives and working groups in respect of themes/trends which are monitored via SIRG's action log. Key themes in 2019/20 were:

- Suboptimal care of patients with diabetic ketoacidosis
- The importance of accurate and timely documentation on eCare
- Medication incidents for missed/delayed doses (especially out of hours/when stock not available)
- Consistency of Waterlow assessments and abuse incidents, including the impact on staff & other patients
- The significance of a no blame, learning culture with effective action plans to evidence compliance against recommendations.

Learning is shared in local and Trust-wide newsletters and governance reports for clinical improvement meetings (CIGS), with escalation reports to corporate governance committees. The Trust established a learning from incidents focus group to engage staff in how best to share/capture learning and held a national study day in September 'challenging the status quo from reporting to learning' which focused on a learning culture and quality improvement initiatives for learning. The Trust also has the Greatix system for sharing learning and congratulating individual staff and utilises the plenary audit afternoons as another forum for learning and encourages cross specialty sessions.

On a wider scale the Trust is represented at the Health Economy Meeting which enables multi agency shared learning linking with the community and mental health teams, hospice etc with presentation of investigation reports with transferable learning.

### 3.2.4 Midwife to Birth Ratio

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

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

At Milton Keynes the Midwife to Birth Ratio is stated on the obstetric dashboard on a monthly basis and reported at Management Board, Women's CSU meetings and Clinical Quality Board bi-monthly. For 2019/20 the Midwife to Birth ratio was reported as follows:

| Month | Midwife to birth ratio |
|---|---|
| April 2019 | 1:29 |
| May 2019 | 1:31 |
| June 2019 | 1:27 |
| July 2019 | 1:28 |
| August 2019 | 1:31 |
| September 2019 | 1:28 |
| October 2019 | 1:27 |
| November 2019 | 1:26 |
| December 2019 | 1:26 |
| January 2020 | 1:28 |
| February 2020 | 1:24 |
| March 2020 | 1:26 |

The average ratio for 2019/20 was 1:27.5

### 3.2.5 Statutory and mandatory training

**Statutory and mandatory training**

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

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

MKUH has been part of the East of England NHS Leadership Academy streamlining programme and all our mandatory training competencies are mapped to the Core Skills Training Framework, (IAT's) Inter Agency Transfers are accepted between ourselves and other CSTF organisations.

There has been a steady improvement in statutory and mandatory training overall at MKUH since 2014 – the table below shows the compliance rate by year and by quarter: to Birth ratio was reported as follows:

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| 2014/2015 | 81% | 81% | 85% | 87% |
| 2015/2016 | 86% | 87% | 88% | 89% |
| 2016/2017 | 89% | 89% | 90% | 91% |
| 2017/2018 | 91% | 89% | 90% | 89% |
| 2018/2019 | 90% | 89% | 90% | 93% |
| 2019/2020 | 93% | 93% | 92% | 94% |

Mandatory training is reported at Workforce Board, Workforce and Development Assurance Committee (quarterly) and Management Board (monthly).

There is a blended approach to mandatory training compliance with face to face classroom practical sessions and e-learning to enable staff to remain compliant. We hold mandatory training roadshows quarterly to help and advice colleagues on mandatory training topics and how to complete training.

During 2019/20, the Trust included Statutory and Mandatory Training in the ESR (Employee Service Record) – allowing staff easy access to check their status and to book on to training sessions as required. Statutory and Mandatory training remains a key performance indicator of quality and contributes greatly towards patient and staff health and safety.

# 3.3 Clinical Effectiveness

### 3.3.1 Cancer waits

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

In May 2016, the National Cancer Transformation Board published a wide range of specific steps designed to increase prevention, speed up diagnosis, improve the experience of patients and help people living with and beyond the disease.

Milton Keynes University Hospital has developed services to ensure live access for the Multidisciplinary teams to all cancer performance targets and a live patient tracking tool to enable management of patient's pathways and early identification of delays and trends of issues. There are weekly escalation meetings managed with the Head of Cancer Services with all operational speciality leads to discuss patient level detail and capacity and demand management.

There is a further weekly overview of the cancer position and risks at the executive PTL meeting, alongside this there are escalation alerts sent to the divisional and executive leads for any pathways that are raising concerns and resulting in patient delays. The Head of Cancer services meets with the MKCCG lead to review cancer breaches fortnightly and presents RCA and risk assessments for these raising concerns as required and identifying actions in place. Both MKUH and MKCCG report the cancer positions back through their board meetings.

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

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

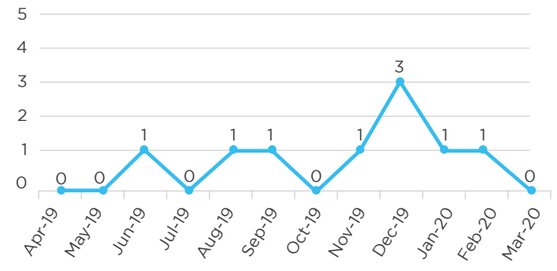
**62-day cancer performance**

| Tumour Site | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Brain | | | | | | 100% | | | | | | |
| Breast | 83.3% | 100% | 85.7% | 87% | 100% | 100% | 94.1% | 93.3% | 91.3% | 77.8% | 80% | 100% |
| Colorectal | 50% | 77.8% | 60% | 25% | 100% | 76.9% | 66.7% | 66.7% | 85.7% | 100% | | 100% |
| Gynaecology | 75% | 50% | 75% | 0.0% | 66.7% | 80% | 66.7% | 16.7% | 50% | 75% | 25% | 42.9% |
| Haematology | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Head and Neck | 0.0% | 0.0% | 33.3% | 0.0% | 0.0% | 28.6% | 63.6% | 66.7% | 66.7% | 100% | 40% | 83.3% |
| Lung | 100% | 100% | 80% | 77.8% | 88.9% | 80% | 66.7% | 100% | 70% | 66.7% | 66.7% | 66.7% |
| Other | | | | | | | 100% | | | | | |
| Skin | 100% | 100% | 100% | 84.6% | 100% | 100% | 94.7% | 100% | 100% | 100% | 100% | 87.5% |
| Upper GI | 100% | 90.9% | 75% | 0.0% | 0.0% | 66.7% | 100% | 50% | 100% | 50% | 0.0% | 66.7% |
| Urology | 100% | 70% | 52.6% | 62.7% | 79.5% | 75.9% | 75.9% | 83.3% | 95.2% | 78.3% | 74.1% | 81.6% |
| **Grand Total** | 85.7% | 85.6% | 74.3% | 68.7% | 85.3% | 83.9% | 84.8% | 85.4% | 89.0% | 84.9% | 74.7% | 82.1% |
| | | | | | | | | | | | | |
| **Including Rarer Cancers (RC)** | **85.9%** | **85.6%** | **74.3%** | **69.1%** | **85.3%** | **83.9%** | **85%** | **85.6%** | **89%** | **85.2%** | **75.3%** | **82.1%** |


### 3.3.2 Long waiting patients

Through the continued and focussed effort of many members of staff, MKUH has continued to keep the number of patients waiting 52 weeks for their procedures to a very low level. Providing care to patients in a timely manner is a key element of the high quality services the Trust seeks to offer, and even though numbers for 2019/20 are very low, our aim is to have no patients at all waiting a year for their planned treatment. Each month, the Trust's Medical Director reviewed patient case notes in order to assess whether the ongoing delay may have led to harm. No physical harm was identified through this review process, but it was agreed by all that such extended waits represented very poor patient experience.

**Reported 52ww 2019/20**



### 3.3.3 Quality Improvement

MKUH aims to be an outstanding acute hospital and one of its strategic aims remains to ensure that its clinical services meet the latest quality standards.

Quality improvement is a key element in the realisation of these aims. While, the ambitions outlined last year have been hampered by the pandemic, with the team temporarily redeployed in February 2020 to focus on Covid-19 roles, Covid-19 has also presented many new opportunities and examples of how change can happen when there is an urgency and has demonstrated the capabilities already within the trust to make meaningful change that will improve patients care, safety and experience.

To date, training in quality improvement has been delivered in a variety of formats to more than 110 staff, together with providing staff access to the team to support improvement ideas and projects, and access to a number of resources to support their projects, and 'Life QI' to register and monitor their change ideas.

The Trust intranet has dedicated QI pages providing staff access to in-house and external online resources and a step-by-step guide to completing a QI project.

Various staff engagement opportunities were held throughout the year including the Event in the Tent QI breakfast club and the QI Dragon's Den, where preceptorship nurses pitched their QI ideas to a panel in order to win support to bring their projects to life. A centrally located drop-in facility was also available for several months that allowed both staff, patients, and visitors to share their improvement ideas and seek support and training.

Over the years, a significant number of improvement projects have been undertaken across the hospital that may not previously have been badged as QI initiatives. Over the last year, the Trust has undertaken a significant programme of work to engage in the implementation of the "Getting it Right First Time" initiative as well as supporting and monitoring various improvement projects. Here are some examples:

- The introduction of the warm baby bundle for babies identified at birth as high risk for hypothermia were given a red knitted hat, specific care advice and mothers were encouraged to maximise skin to skin contact. The benefits included a reduction in the number of babies developing hypothermia, reduction in avoidable admissions of term babies to the neonatal unit and a less separation of mother and baby in the early stage of life.
- The introduction of inter-professional immersive ward simulation for foundation year doctors aimed to improve communication and team collaboration and reduce the number of related healthcare errors. 97% of participants rated the simulation as excellent with improvements reported in both technical and non-technical skills.
- An initiative to improve the identification of healthcare staff using patient information leaflets and posters explaining the different job roles and uniforms and introducing role specific coloured lanyards for doctors. Both staff and patients reported finding the initiative aided identification and reduced confusion.
- Initiatives aimed at reducing the number of pressure ulcers on an acute elderly male care ward with a rising rate of avoidable and non-avoidable pressure ulcers. With the introduction of safety crosses and staff education, there was a notable improvement in the completion and documentation of admission and daily skin assessments from 68% to 96%. Together with the trial of 'noodle' mattresses, there was a 57% reduction in the number of pressure ulcers over the 4-month period.
- As part of the national maternity neonatal safety collaborative programme, an improvement initiative was developed to improve the early recognition and management of sepsis in women and their neonates. The aim was to ensure that 90% of women and babies were managed appropriately alongside our local guidelines and thereby reducing the number of neonates receiving unnecessary IV antibiotics. Further initiatives are currently underway focusing on the management of neonatal sepsis.
- Initiatives to reduce the number of contaminated blood cultures as a result of poor compliance to aseptic non-touch technique (ANTT) principles such as handwashing, wearing of PPE (personal protective equipment) and skin preparation. Key areas of focus were identified with targeted staff training and assessments as well as trust wide 'ANNT April' awareness month and updates on current practices, devices and products were made available to all clinical areas. During the 4 months post the interventions, there was a 24% decrease in the number of contaminated blood cultures.



# 3.4 Performance against key national priorities

| Indicator | Target and source (internal /regulatory /other) | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|
| Maximum waiting time of 31 days from diagnosis to treatment for all cancers* | 96% (National) | 99.6% | 99.2% | 98.0% |
| Maximum waiting time of 62 days from urgent referral to treatment for all cancers* | 85% (National) | 88.2% | 83.9% | 81.1% |
| Maximum wait of 2 weeks from GP referral to date first seen for all cancers* | 93% (National) | 95.9% | 96.4% | 94.3% |
| Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments* | 98% (National) | 100% | 100% | 99% |
| Maximum waiting time of 31 days for subsequent cancer treatments: surgery* | 94% (National) | 100% | 98.9% | 98.6% |
| Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients* | 93% (National) | 96% | 96.4% | 97.5% |
| Referral to treatment in 18 weeks – patients on incomplete pathways** | 92% (National) | 90.7% | 87.4% | 85.5% |
| Diagnostic wait under 6 weeks** | 99% (National) | 99% | 98.7% | 98.9% |
| A&E treatment within 4 hours (including Urgent Care Service)** | 95% | 91% | 91.4% | 88.8% |
| Cancelled operations: percentage readmitted within 28 days** | 95% (National) | 67% | 70.4% | 86.5% |
| Clostridium difficile infections in the Trust** | 39 (National) | 13 | 15 | 14 |
| MRSA bacteraemia (in Trust)** | 0 (National) | 3 | 1 | 0 |

**As at the end of Q2 2019/20 (M10)  ** As at the end of January 2020 (M10)*

# Statement from Milton Keynes Council Quality Accounts Panel

## Milton Keynes University Hospital NHS Foundation Trust

The Panel welcomes the opportunity to comment on the Milton Keynes University Hospital NHS Foundation Trust Quality Account 2019-20.

Firstly, the Panel would like to commend MKUH for completing their Quality Report given the great deal of strain that Covid-19 must have placed on other demands for their time and resources over the period it needed to be prepared.

The priorities chosen in the Quality Account are clear as to what MKUH is looking to achieve. However, it may be useful to use more facts and figures to illustrate the why of the choice of these particular issues. The report would also benefit from setting out the SMART indicators that will be used to measure success. The Panel would also question given the ongoing impact of Covid-19 what the reality of achieving the stated priorities will be given the significant focus that will have to remain on treatment of Covid-19 patients. The Panel note that this is raised in the report as an issue that would be kept under review and completely agreed with this approach.

In general, the report is easy to read but is quite text dense. This may be due to the nature of the early draft that the Panel reviewed but its accessibility to lay readers would benefit from being broken up with images and graphs for example.

The panel was very impressed with the involvement of MKUH in clinical research but again this could benefit with more detail to introduce this section of the report.

It would also have been helpful to have a note on how the new stand alone Cancer Centre performed in the midst of the Pandemic.

The panel was disappointed to note that Urgent and Emergency Services and Surgery had been graded as 'Requires Improvement' by the CQC. It should be noted that these two areas are the main reason residents of Milton Keynes come into contact with the hospital thus making the performance paramount hopefully the narrative at paragraph 2.7.3 indicates the pathway to improvement but had nothing but praise for the other services at the hospital which were rated as 'Good'.

The panel felt it positive to see the arrangements for safe working hours and the opportunities staff had to raise any concerns.

Overall, as always, the Quality Report from MKUH is a very good report.

**Milton Keynes Council**
**Quality Accounts Panel**

# Statements from Milton Keynes Healthwatch

MKUH is to be congratulated for producing a Quality Account at a time when considerable demands are being placed on the hospital and its staff. The document is clearly structured, thorough and objective, and the emphasis that it places on patient experience is very welcome. The introduction lays out clearly the constraints imposed on this year's account, and the Chief Executive's report is concise and objective, covering all major points. As always, it is difficult to reconcile the level and detail required of a Quality Account with the simplicity needed to achieve a patient and public friendly document, but this is a creditable attempt.

Healthwatch Milton Keynes are pleased to see that *Priority 2: Improvements in Outpatients efficiency* has been retained and are interested to see what systems and processes have taken the place of the Red2Green initiative. We look forward to working with the Trust to review patient experience and assist in embedding patient, family, and carer views into this vital piece of work.

NHS

**Milton Keynes University Hospital**

NHS Foundation Trust

Standing Way,
Eaglestone,
Milton Keynes,
MK6 5LD.

01908 660033

**www.mkuh.nhs.uk**