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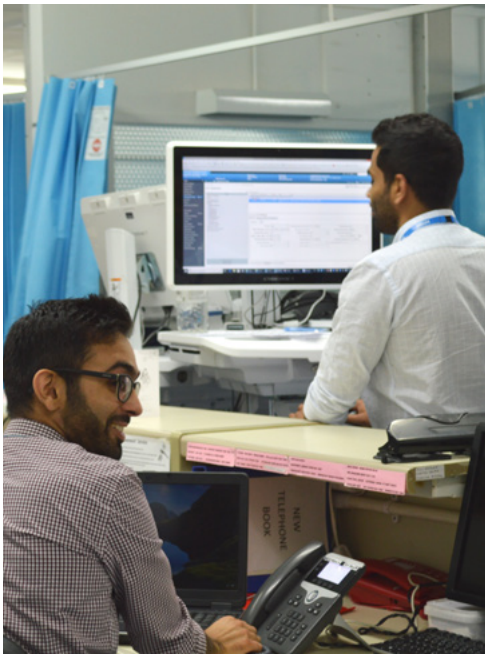
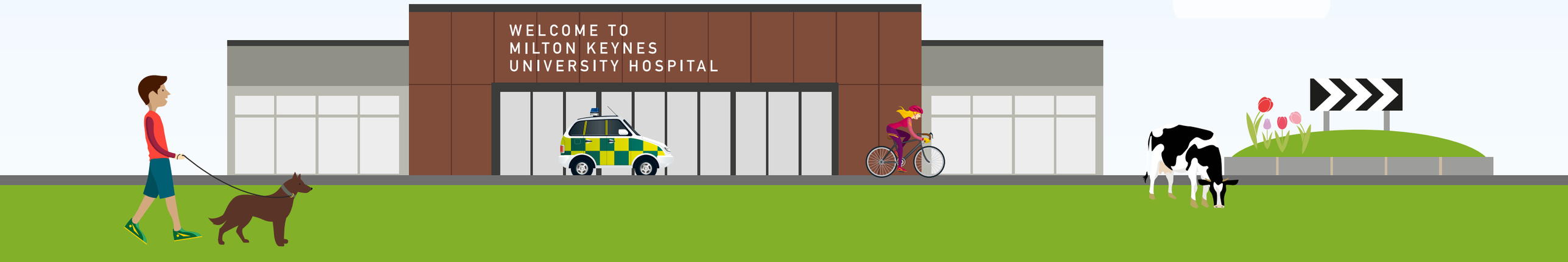


2020/21

MKUH Quality Report

Contents



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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.

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

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

Specifically, the purpose of the Quality Report is to enable patients and their carers to make well informed choices about their providers

The Trust's values are:

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 (2020/21) is to select at least three quality priorities for the year ahead (2021/22). 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 2020/21 and gives a general overview and evaluation of how well the Trust has performed across a range of quality metrics throughout the year.

"We are proud of our professional, compassionate staff and of our strong relationships with local stakeholders."

1.2 Statement on Quality from the Chief Executive

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

The Quality Report provides us with a chance to look back on how we improved our quality of care provided to patients throughout 2020/21, and where there are opportunities to make further improvement moving into 2021/22 and beyond, to ensure our services are as safe and as effective as they can be and that the patient experience is as good as it can be.

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

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

One of the success stories during 2020/21 was the hugely positive impact of our new Cancer Centre on the care and treatment of patients. Since the new centre was opened in March 2020, seeing all of the hospital's cancer services brought under one roof for the first time, the feedback from patients, families, visitors and staff has been overwhelmingly positive. In a year when good news has at times been difficult to come by, the Cancer Centre has provided some welcome positivity in the way it has been received and in the way that it has helped staff to deliver a first-class service to patients and visitors.

Our plans to further develop our estate have continued into 2020/21, in spite of the pandemic, as we began construction work on a new Pathway Unit next to the Emergency Department, where the old Maple Unit was situated before it was demolished.

The Milton Keynes population is one of the fastest growing in the UK, with half a million expected to be living in the town by 2050, so it is important that our hospital continues to expand and improve its services, facilities and infrastructure in order to meet the demands that will come with that increased growth, so that we maintain our quality of care. Planning continues apace for this expansion, which includes a new Women's and Children's Hospital, surgical block and imaging centre in the coming years. These service improvements will help to further improve the quality of our treatment and care to patients, helping us to achieve our objectives in line with our responsibilities to the development of Milton Keynes as a town, and we will continue to work with our partners and engage with the public in order to deliver on these.

Another way in which our Trust has improved its services through 2020/21 is through the increased use of technology. Our hospital is constantly seeking ways to embrace technology to enable our staff to work better and more smartly, more efficiently and more effectively, and to help to provide services to patients in the way that they would like to receive them. These innovations have included further developments to the MyCare app, expansion of the eCARE system (electronic patient records) and a collaboration with Apple Health to improve the level of access to patient records for both staff and patients.

"Our aim is for every patient to benefit from excellent care provided by our Trust, and we seek to deliver this excellent care by making these objectives the driving force behind everything we do as a hospital"

The time saved by staff through the use of new technologies allows them to spend more time focusing on treating patients.

Another example of technology being put to good use was the introduction of smartphones on wards for patients to use to contact loved ones when visiting restrictions were in place during the pandemic. Technology also helped us to significantly increase the number of virtual clinics that we could provide to patients. These virtual appointments have saved the equivalent of ten trips around the world. This reduced the numbers of cars on the road in Milton Keynes, freed up car parking spaces at the hospital, reduced the footfall on site and therefore, also reduced the number of potential transmissions of COVID-19 in the hospital.

In early 2021 we launched our Virtual Library of patient information leaflets on the Trust website, providing hundreds of leaflets digitally which can now be accessed by patients online, helping the Trust towards its aim of being a paperless organisation whilst also giving patients wider choice as to the ways in which they can access information.

In terms of performance, this year has been challenging in terms of maintaining services whilst providing care through the pandemic. The Trust was placed in the top quarter of hospitals across the country for our emergency performance in assessing, admitting, or discharging patients within four hours. Our cancer performance did drop in terms of the numbers of patients overall being treated within 62 days, and this again was one of the effects of the pandemic. All of our quality performance indicators are published at every Trust Board meeting in order that the public can view our performance against national, internal and peer-benchmarked metrics, with indicators including statistics for infection rates, pressure ulcers, serious incident figures and mortality measures.

Patient experience is always important to us, and the number of complaints received by the hospital dropped from 1,227 in 2019/20 to 829 in 2020/21. The Trust also dealt with 352 complaints within 24 hours of receiving them in 2020/21, which was a significant increase compared to the figure of 108 for 2019/20. We continue to welcome and actively seek feedback from patients who receive treatment and care from us so that we can continue to find ways to further improve the quality of care that we provide.

There is no doubt that 2020/21 was a very challenging year for all, but we move into 2021/22 with positivity.

1.3 Statement of Assurance

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

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

During the year – as far as possible within COVID-19 pandemic restrictions - we have continued to be actively engaged with the Milton Keynes Council Health and Adult Care Select Committee and the Health and Wellbeing Board on subjects of importance to the community.

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

The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to the best of my knowledge, the information in the document is accurate.

Professor Joseph Harrison
Chief Executive

08 July 2021

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Priorities for Improvement and Statement of Assurance from the Board

2.1 Priorities for Improvement in 2021/22

This section of the Quality Report describes the areas we have identified for improvement in 2021/22. In March 2021, 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 2021/22 were continued from 2020/21 because the delivery of the 2020-21 priorities were significantly impacted by the operational challenges of the Trust's response to COVID-19. The Trust has deemed it appropriate to continue with these priorities for 2021-22, refreshing the metrics and objectives, and considering ongoing COVID-19 priorities.

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.

1 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 show 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 were never less than 4mmo/L and there were no more than two readings showing blood sugar levels higher than 11mmo/L).

How will we monitor and measure our performance in 2021/22?

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.

2 Priority 2: Improvements in Outpatients Efficiency

This is a continuation of one of the priorities for 2020/21, 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. Due to the significant impact of the COVID-19 pandemic in 2020/21, there were 313,363 outpatient attendances from 383,764 outpatient attendances in 2019/20 and 383,036 in 2018/19. With the growth of the town and the decline of COVID-19 infections however, outpatient activity is predicted continue its upward trajectory 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 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 2021/22?

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.

3 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 straight forward. 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.

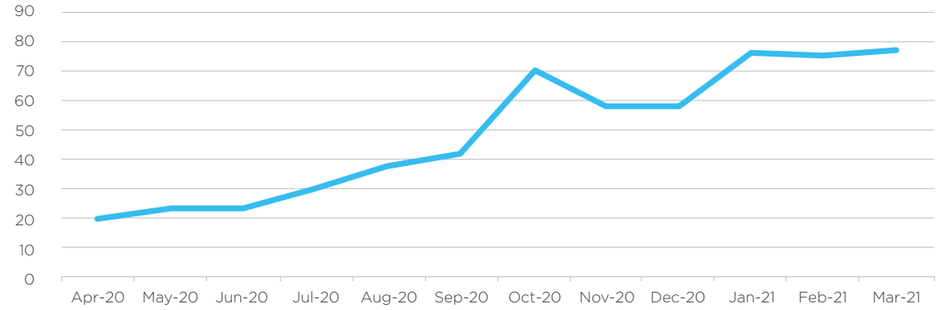
National audits looking at reasons for longer lengths of stay typically show that up to half the reasons why patients are not discharged earlier are under the direct control of the hospital itself. We are therefore supporting wards to adopt and embed proactive approaches to managing patient pathways 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?

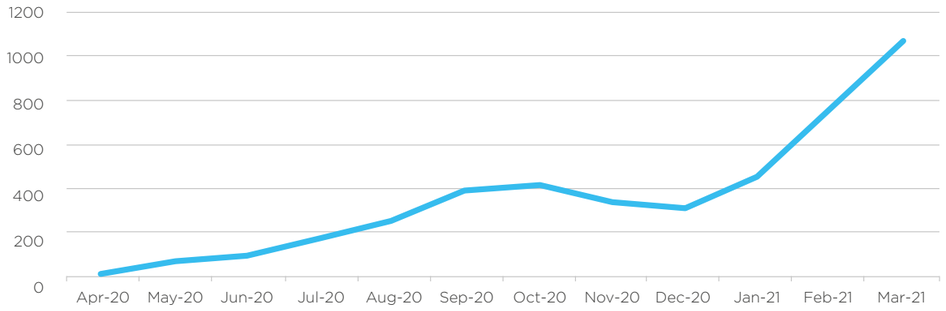
Compared with other similar Trusts in the region, MKUH does need to reduce the length of stay for patients admitted in an emergency. We have higher numbers of patients staying over 21 days, particularly in medical beds. We could also do better when comparing our performance on length of stay for people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

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



Due to the impact of the COVID-19 pandemic on the Trust's clinical operations, the number of patients who have waited for 52 weeks or more on the waiting list increased from 0 in April 2020 to 1,073 in March 2021.

Number of >52 week waiters on RTT waiting list at MKUH



How will we monitor and measure our performance in 2021/22?

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 monthly to the Transformation Programme Board through the Length of Stay Programme Board.

2.2 Our Performance against Priorities for Improvement in 2020/21

Priorities for 2020/21:

1. Improving Care for Inpatients with Diabetes

2. Improvements in Outpatients Efficiency

3. We will reduce length of stay for our older patients

Due to the significant impact on operations by the COVID-19 pandemic, the 2020/21 Priorities were not progressed. As they remained valid, the Trust decided to roll over the 2020/21 Priorities into 2021/22 while refreshing the metrics and objectives and considering ongoing COVID-19 priorities.

2.3 Statement of Assurance from the Board of Directors

During 2020/21 Milton Keynes University Hospital NHS Foundation Trust provided and/or sub-contracted 36 relevant health services.

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

The income generated by the relevant health services reviewed in 2020/21 represents 100% of the total income generated from the provision of relevant health services by Milton Keynes University Hospital NHS Foundation Trust for 2020/21.

2.3.1 Clinical Coding Audit

During 2020/21, 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 2020/21 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.

During the COVID-19 pandemic, many of the National Clinical Audit programmes were suspended. The team at Milton Keynes University Hospital used this hiatus to review the audit database and make improvements relating to ease of use and the reporting methodology. This revised database will allow users to access the clinical audit data and updates more easily. Some of the National Clinical Audit reports have been published. The recommendations have been shared and the clinical teams have responded to adopt any revised practice.

For 2020/21 Milton Keynes University Hospital participated in 48 clinical audits and programmes as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), as well as providing data for the Clinical Outcome Review Programmes.

There is evidence of good practice, learning and action planning from the National Clinical audit programme across the organisation. Performance and support for both NCA participation and implementation of service development is offered via the Clinical Audit & Effectiveness Board and the Clinical Service Units. It should be noted that despite the challenges posed to the clinical teams throughout 2020, participation in service improvements and uptake of new technologies has been exemplar.

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.	Data submitted monthly on an ongoing basis. We validated our data on time for the latest year (2019-20); the 2020 summary report (2017/18/19 data) has been published and reviewed.
BAUS Urology Audits: Nephrectomy	Yes		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 2019The data for these registries was published in 2020. The reports from BAUS published in March 2021 have been reviewed for actions. National Current outcome data is used for the doctor's appraisals and revalidation.
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 was published in 2021 and reviewed for actions. 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.

Name of Audit	Did MKUHFT participate	Number of cases submitted	Findings & recommendations – Local & National reports	Changes & actions
National Bowel Cancer Audit (NBOCAP)	Yes	**128** submitted in 2019. Data Source: National database Criteria: Diagnosis and Tumour from extract National Gastrointestinal Cancer audit (NGCA) data **167** submitted in 2019 Data Source: National database Criteria: Diagnosis and Tumour from extract	Adjusted 30-day unplanned readmission rate 9.6% (national average 10.8%) Adjusted 2-year mortality (%) 24% (national average 18.9%) Patients with complete pre-treatment staging & recorded performance status 100% (green) Data completeness for patients having major surgery 70% (amber)	This audit forms part for the National Gastrointestinal audit programme. Annual report and Local data are due for review at the next Bowel Cancer MDT. Data for both audits provided. Recommendations from the June 2021 report have been reviewed by the team for actions.
Cardiac Rhythm Management (CRM)	Yes	Ongoing submission	Data submitted monthly on an ongoing basis.	We validated our data on time for the latest year (2019-20); the 2020 summary report (2017/18/19 data) has been published (https://www.nicor.org.uk/wp-content/uploads/2020/12/National-Audit-of-Cardiac-Rhythm-Management-NACRM-FINAL.pdf) and the recommendations will be reviewed.
Case Mix programme (CMP) ICNARC	Yes	Awaiting numbers from RS		Localised ICNARC COVID-19 data - MKUH have had benchmark outcomes related to COVID-19 admissions. We intubated less patients and our population was younger than benchmark. Lots of learning has been implemented which has improved outcomes.

Name of Audit	Did MKUHFT participate	Number of cases submitted	Findings & recommendations – Local & National reports	Changes & actions
National Paediatric Diabetes Audit Diabetes (NPDA)	Yes	Continuous data collection	No CHO counting at diagnosis Small numbers using Continuous Glucose Monitoring (CGM) Data suggested > expected high/ normal and high blood pressure (BP) Data demonstrated higher than expected overweight and obese patients	We will fully participate with all PREMS surveys as previously. We will look at possible use of tables/ IT in clinic to try and increase uptake. Already excellent relationship between PDSNs with schools as noted in in Peer Review 2020. Established group sessions with additional training as needed as well as regular updates to patient care plans. PREM results reviewed in MDT with actions. access to specialist diabetes advice to patients Provided in working hours by the Diabetes Team and provided my Paediatric Registrars out of hours. psychology support provided remotely throughout COVID and now face to face Waiting area reviewed with recent addition of diabetes specific information about HbA1c and Time in Range - Ormskirk model. Self-management - Discussed in clinic and documented as part of annual review process in SPARKLE database. Patient training in place. MDT team to review practice of refreshers at clinic. Preparing young people and their families for transition from Paediatric to adult services. Transition process starts at age 12years with slow introduction of independent clinic time in a supported way. This develops over time with increasing discussions being centered on independent management. Prior to 16 birthday plans for family to meet adult DSN before then formal Transition clinic with adult service once 16 years. Time of move to adult service decided jointly by patient, family and MDT at a time that is suitable for the young person.

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 2020 report 21.2 (England average 22.3)	Report from 2020 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. The next report for hip and knee replacement procedures will be published on 12 August 2021
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	National falls audit - 16 cases submitted NHFD – 300 cases FLS – 295 cases	Programme includes national hip fracture database (NHFD), fracture liaison service database (FLS-DB) and national audit of inpatient falls 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. Delay in getting patients to theatre	Consideration to taking down elective lists to fit more trauma work. 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). NHFD report received and responded to by the Fragility nurse. T&O Team acknowledge receipt of the report and recommendations initially presented – further presentation to take place in next months' meeting to consider action plan. Falls are reviewed at SIRG and RAG rated. Learning is disseminated across the organisation and interventions out in place.
Head and Neck Cancer Audit (HANA)	N/A	MKUH does not participate due to low numbers		

Name of Audit	Did MKUHFT participate	Number of cases submitted	Findings & recommendations – Local & National reports	Changes & actions
Inflammatory Bowel Disease (IBD) programme	Yes	Continuous data collection	Report for 2020/21 published February 2021 989 patients submitted	Team involved in review of patient pathway. Telephone consultations successful in connecting with patients. Actions from audit • Record drug stop dates particularly for steroids, immunomodulators and biologics • Consent is still paused – but continue recording and submitting records. They can flow to us under the Section 251 exemption from consent we hold • Before starting a 5-ASA drug in your patients with Crohn's disease, consider the guidance on efficacy (see section 5) • Whenever possible when starting a course of oral steroids set a provisional stop date no more than 8 weeks later.
Learning Disability (LD) Mortality Review Programme (LeDeR)	Yes	Continuous data collection		Medicine and Surgery Divisions ensure review of LeDer deaths where these have been identified. 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	Quarterly Submission	Awaiting additional information from TARN Coordinator.	25/05/21 TARN report has been presented to the T&O team The Trust is within or above the expected ranges for all indicator nationally. Data submission has improved Improvement is required in certain areas including transfers. Rehab prescription requires a Band 7 review and sign off. The Trust does not have this in place. Head injury data discussed.
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Continuous data collection	Awaiting audit presentation – to be presented in March audit meeting	The findings were presented at the CIG meeting, and the findings of the last MBRACE report discussed and practice reviewed. Actions to improve inequalities in maternal mortality rates have been implemented
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	259 (01/04/2017 – 31/03/2018) submitted in 2019. Patients 50 years and over 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 July 2020 this was presented in June 2020 to Breast MDT. 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	NAD 2020-22 Please be advised that due to the current situation with coronavirus (COVID-19) the audit timelines have changed	Rcpsych are aiming to roll out the next round of audit for all hospitals in 2022 and this will be informed by the current pilot and evaluation process. We will provide further information about this at the end of 2021.
National Audit of Rheumatoid and Early Inflammatory Arthritis	No	Continuous data collection	Regional Level and Trust Level QS7 Annual Review findings are online. All domains are RAG-rated 'green' apart from the Annual Review and Disability Assessment.	The Supplementary report presenting data captured at 12 months and results from data linkages (Enrolment window: 8 May 2018-7 May 2019) was published in January 2021. The results and recommendations have been shared and actions in place. This is the information specifically to MKUH Participation by Trust/Hospital – 66 Proportion of patients meeting QS1 – 33& Conversion to EIAA – 92% Proportion of patients meeting QS2 – 38% Proportion of patient meeting QS3 – 61& Proportion of patients meeting QS4 – 91% Proportion of patients meeting QS5 – 91% Proportion of patients meeting QS6 -100%

Name of Audit	Did MKUHFT participate	Number of cases submitted	Findings & recommendations – Local & National reports	Changes & actions
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Continuous data collection	Report published January 2019	Data submitted. We were part of the ORENC group. Quality standards have been shared and reviewed. **Current status:** 1. Well run Pediatric Epilepsy service led by a 100% WTE Consultant Paediatrician with expertise in Paed Epilepsy 2. Figures for appropriate Clinical assessment, investigations, Referral, Diagnostic certainty, Communication of care plan are comparable if not better than regional and national average 3. Incidence of prolonged convulsions is far lower than Regional and national average 4. Safe prescription of teratogenic medications is comparable to regional and national audit data 5. Provision and delivery of designated epilepsy clinics, satellite tertiary neurology clinics and transition clinics is comparable to regional and national data 6. 60% of new patients were seen in the epilepsy clinic within 8 weeks Vs 30% regional and national average. **Actions:** 1. SUDEP-we are working towards this. 2. Paediatric Epilepsy Nurse Specialist (PENS)-initial discussion with CSU lead and managers held. 3. Increasing the clinic numbers-No capacity. 4. Best Practice Tariff/Targets-not possible based on the current job plan and lack of support from PENS/CAMHS team etc. 5. Pathway for referral-agreed with tertiary neurology team at Oxford.

Name of Audit	Did MKUHFT participate	Number of cases submitted	Findings & recommendations – Local & National reports	Changes & actions
National Cardiac Arrest Audit (NCAA)	No	Currently collected.	Data collection and submission ongoing.	Results presented at Critical care delivery group. Actions relating to standardizing the trolleys and education have been implemented. New trolleys in place. A Retrospective evaluation of DNACPR documentation in MKUH during peak COVID-19 period (May 2020 - August 2020), and documentation 8-9 months later (April 2021) has been undertaken. **Identified outcomes –** 1. 100% compliance in Identifier Data 2. 19/130 forms did not have consultant countersignature within 24 hours 3. 25/130 from did not have completed Review of DNACPR details 4. Discussions with relevant other person: 65% completed in first cycle, 46.7% completed in second cycle - lots of room for improvement. 2. A review of DNACPR decision-making in COVID-19 2020 has been undertaken, looking for bias in decision-making. No bias has been found and qualitative data suggests good practice in communication with patients and families regarding decision making.
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Yes	Continuous data collection	Met best practice tariff (BPT) continuously since January 2019 Noninvasive ventilation (NIV) – variable but generally above national average Smoking cessation – above national average for referrals Oxygen prescription – well below national average Spirometry- below national average	**Key Successes** 1. Follow-up clinic was satisfactory 2. % patients administered steroids was good Concerns are in line with national findings regarding inhaler check, personalized plan & discharge bundle.

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 Comparative Audit of Blood Transfusion 2019 Re-Audit of the Medical Use of Red Cells Periodic Feedback Report published for 2019 data	Periodic Feedback Report reviewed and results shared. For 26/36 (72%) patients a pre-transfusion Hb was taken on the same day as the transfusion. 10/36 (28%) patients had their Hb tested within the 3 days prior to the transfusion. 9 patients with cardiac and/or respiratory disease were given a transfusion when their pre-transfusion Hb exceeded 80 g/L 4/36 (11%) patients a post-transfusion Hb was taken on the same day as the transfusion. 30/36 (83%) patients had their Hb tested within the 3 days following the transfusion. 17/38 (45%) patients had more than one unit of red cells transfused. Of these, 5/17 (29%) were either bleeding or could be considered to be on a chronic transfusion programme. This leaves 12 patients who should be checked between units. 30/38 (79%) patients there was evidence that the risks, benefits and alternatives to transfusion were discussed Audit of Red Cell use within the trust on-going – interrupted by COVID-19 Blood sample rejection rates audit complete and presented in April 2021. Actions in place.
National Diabetes Audit – Adults	Yes	Continuous data collection.		Local actions suspended due to COVID-19 disruption to service.
National Emergency Laparotomy Audit	Yes	Data being submitted for the 5th report	Report expected November 2021	**Key successes are noted as** 1. good high-level collaboration with other trusts to pool idea for QI, 2. Excellent collaboration between surgeons / anesthetists in data entry Improved case ascertainment 63% to 72.8% 94 cases submitted.

Name of Audit	Did MKUHFT participate	Number of cases submitted	Findings & recommendations – Local & National reports	Changes & actions
National Heart Failure Audit	Yes	Continuous data collection. 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.	Application of gold-standard echocardiography testing remains acceptable overall, nut ward-based variation needs improvement. Prescribing rates of key disease modifying medicines for those with HFrEF have continued to increase. The proportion of patients admitted to cardiology wards is static ant <50% and leaves scope for improvement Heart failure patient follow-up has improved and multiple alternative KPIs have been met.
National Joint Registry (NJR)	Yes	Latest data 100% consent rate.	Awaiting latest report. Acknowledged for excellence in data submission 100% consent rate.	Since the Audit report reviewed in November 2019 where MKUH identified as an outlier for hips/knees, the action plan implemented address issues included – surgery stopped, ring fenced beds and review of all cases of revision. Monitoring of data continued to ensure improvements. The next report will be published in September 2021.
National Lung Cancer Audit (NLCA)	Yes	Continuous data collection	Last NLCA report published Jan 2020 and spotlight on curative intent in July 2020	Action panning interrupted by COVID-19. Review in progress. The team is in the process of auditing 2 months from last year to 2 months this year to compare like for like. We have already started documenting PS more accurately which was felt to be the main issue, and have a new data upload clinical sign off before each submission.

Name of Audit	Did MKUHFT participate	Number of cases submitted	Findings & recommendations – Local & National reports	Changes & actions
National Maternity and Perinatal Audit	Yes	Continuous data collection	Against national average: PPH rate low (1.6%) Induction rate lower (21.3%) C section rate is lower (24.8%) Early elective delivery rate higher (31.3%) Undetected SGA is higher (55.3%) Low spontaneous vaginal delivery rate (62.5%)	Validation of clinical coding for PPH Significant PPH have been reviewed at SIRG and learning from case reviews shared with the teams.
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	Continuous data collection	2019 date reported in the NNAP 2020, published April 2021.	Key recommendations under review for learning and implementation.
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	Audit report published December 2020	Audit recommendations reviewed. Regarding the MDT - The MDT is generally quorate although there are still occasions where it is not. Attendance to be monitored through the cancer transformation group(informal) and escalated to the contract meeting where necessary. The service is undergoing a degree of transformation following a change in Consultant and a review of the upper GI pathway is underway. The CCG and Trust are combining transformation resource to support change.
Paediatric Intensive Care (PICANet)	Yes	Continuous data collection	We do not actively participate in PICA net	The Summary Report Paediatric Intensive Care Audit Network Annual Report 2020 for Data collection period January 2017–December 2019 has been reviewed for any applicable local learning.
Pain in Children	Yes	Continuous data collection	Acute pain team review	Paediatric Pain MDT group created. Review of Paediatric Pain pathways by Acute pain team. New protocols related to the use of PCA in in-patients and pain in patients with sickle cell crises.
Perioperative Quality Improvement Programme	Yes	Continuous data collection	56 patients were submitted to the audit in 2019 (with completed data sets).	Awaiting opportunity to present the findings at a surgery / anaesthetics MDT. PQIP annual report publishing date 9th Sept 2021. PQIP will be using data provided up until 5th July at 5pm.
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. Improvement tool selected to be presented at national conference.

Name of Audit	Did MKUHFT participate	Number of cases submitted	Findings & recommendations – Local & National reports	Changes & actions
National Prostate Cancer Audit (NPCA)	Yes	169 patients submitted in 2019. Data Source: COSD	Recording PSA results - considerably lower than national data. Membership did not agree with the results. Currently best nationally. Multiparametric - considerably lower than national data.	169 patients submitted Previous report in February 2019 had been reviewed and benchmarked against. Short report for prostate biopsies had been reviewed. 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. **Actions** Review of data undertaken May 2021 and RAG rated. No domain red – predominantly green with some amber. 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% Stroke Nurse within 24hrs - 97% OT/Physio assessments within 72hrs - 100% Thrombolysis within 1hr - 83% Transferred to Stroke Unit with 4hrs - 78% At least 90% stay on Stroke Unit - 89%	Review SALT services in community & Trust/SLA review 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.
UK Parkinson's Audit	Yes	Continuous data collection		No actions from reports.

Name of Audit	Did MKUHFT participate	Number of cases submitted	Findings & recommendations – Local & National reports	Changes & actions
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. We have a community hub at Willen, with 5 diabetes specialist nurses and a 0.5WTE consultant, fulfilled by 2 consultants. We work with our primary care colleagues through-Virtual clinics Joint clinics Assessment clinics Annual diabetes conference We have an integrated triage system for all but emergency referrals (RMS), triaged by consultants	Created an annual diabetes conference Structured education for patients-DAFNE for type 1 DM and DESMOND for type 2 DM. 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 Late recognition of dying Lack of Palliative Care Team at the weekend	**What did we do well at in the Trust?** 1. Individual plan of care 2. Governance 3. Work force/ SPC **What do we do less well?** 1. Clearly did not get it right for some families who responded to the feedback questionnaire 2. Poor communication, lack of privacy, lack of side rooms are areas that need addressing.
National Asthma and COPD Audit Programme (NACAP).	Yes		Data submitted throughout 2019/20	**Findings 2019/20** BPT met continuously since Jan 2019 NIV – variable position but above national average Smoking cessation above national average for referrals Oxygen prescription below national average Spirometry below national average Actions around above findings have included educational packages for oxygen prescribing. Junior doctor teaching. Escalation regarding spirometry teaching resource.

During 2020/21, to ensure that front line clinical duties were not interrupted during the COVID-19 pandemic, the majority of data collections for the audits and enquiries for the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies were suspended. Some questionnaires and/or data were completed for the following studies.

National Confidential Enquiry into Patient Outcome and Death Study Eligible 2020/21	Participated
Assigned Alcohol Related Liver Disease	Yes
Physical Health in Mental Health Study	Yes
Dysphagia in people with Parkinson's Disease	Yes

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 2020/21 were recruited to participate in National Institute of Health Research (NIHR) studies approved by a research ethics committee. In 2020/21 over 4,553 patients were recruited to 86 studies in the Trust. The Research and Development Department received over £ 780,000 for 2020/21 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 2021/22 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. Virtual and on-line Good Clinical Practice (GCP) training, Principal Investigator study support services, and study specific training. These courses are open to our staff and other research staff across the Thames Valley and South Midlands Clinical Research Network.

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

Our research activity has contributed to the evidence base for healthcare practice and delivery, and in the last year (2020/21) a number of publications have resulted from our involvement in research, demonstrating our commitment to improve patient outcomes and experience across the NHS.

The R&D team, managers, research nurses and other research staff also delivered much of the mask FIT testing at MKUH and have worked tirelessly to support the key COVID-19 studies and to maintain critical non-COVID-19 studies throughout the pandemic. It is worth restating our view that the pandemic demonstrated in the clearest way possible the importance of resilient health and social care systems, the importance of staff, technology and materials and the critical importance of data and of clinical and basic science research in tackling the challenges of the pandemic. We hope that this will lead to greater investment in research and development in the future to tackle other challenges such as developing life-saving therapies for cancer, heart disease and inflammation.

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

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

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

2.6 Goals agreed with Commissioners

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

2.7 Care Quality Commission (CQC) Registration and Compliance

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

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

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

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

2.7.1 Review of Compliance of Essential Standards of Quality and Safety

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

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

2.7.2 Overall Ratings for Milton Keynes University Hospital:

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

2.7.3 Key Findings from the CQC Inspection Report:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

2.7.4 Areas of Outstanding practice

Outstanding practice

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

In maternity:

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

In medical care:

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

2.7.5 Areas of Compliance or Enforcements

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

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

In urgent and emergency care:

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

In relation to surgery core service:

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

2.8 Data Quality

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

Some of the notable actions include:

1. The Data Governance Meeting (DGM) is embedded within the Trust governance framework which continues to review the data quality across the Trust. The DGM seeks to receive audit and compliance reports and additional reports highlighting the data quality underpinning key performance indicators enabling the triangulation of poor data quality and oversee actions plans to address them.
2. The continued work of the Systems/ Training team has a remit to provide expert advice and guidance on matters of system data quality and a dedicated, ongoing data quality training programme. The Systems/Training team receive feedback from compliance audit reports and areas of poor data quality otherwise identified and work with the Divisions to identify and training needs and support staff with system use. In addition, this team continues to develop supporting documentation and training resources to reduce the risks of poor data quality through poor data entry and developing SOPs (standard operating procedures).
3. Fully developed system assurance reports covering key Trust systems used in support of patient care. Where areas of poor practice have been identified which have contributed to poor data quality, Executive Directors have developed action plans to address these shortcomings. The development of action plans and monitoring the delivery of actions is undertaken by the DGM. The Trust has committed to expanding the delivery of system assurance reports to cover all Trust systems as part of ongoing improvements to data quality in the next financial year.

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

The Trust submitted data records during 2020/21 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 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	99.6 (99.5)	99.7 (99.7)	98.6 (97.9)
Completeness ethnicity	99.1 (95.7)	98.7 (93.6)	98.3 (91.8)

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

2.9 Qualitative Information on Deaths (While Maintaining Patient Anonymity)

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

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

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

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

Our rate of referral for investigations did not reduce in Q4 despite our rate of deaths which increased significantly because of COVID 19. Rapid reviews were facilitated during this time which meant families concerns were dealt with quickly.

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

The Learning Disabilities Mortality Review (LeDeR) programme is established in the Trust to review the deaths of people with a learning disability, to learn from those deaths and to put that into practise. The Trust reported 14 deaths to the LeDeR programme in the last financial year The Trust has a full-time learning disability coordinator who supports the pathway for the SJR process with LeDeR review. This takes place as part of the BLMK review group and allows for independent review. Recommendations from the review are put into practise. Some of the actions we are taking include improving communications with families, learning disability awareness to ensure adjustments, assessments and formal processes such as DOLs are followed. We now have a specialist Learning Disability Nurse to advise and support staff, carers and patients.

We reviewed the processes for our perinatal mortality reviews. All perinatal losses that meet threshold are reported to PMRT. The cases undergo an investigation by the team and learning from PMRT is disseminated via different forums and meetings as well as the maternity newsletter. Some of our actions we are taking involves reviewing and updating all guidelines, staff education, workshops to improve fetal monitoring and strengthened governance.

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

Investigations of Deaths 2020/2021

	Q1 Apr-Jun 2020/21	Q2 Jul-Sep 2020/21	Q3 Oct-Dec 2020/21	Q4 Jan-Mar 2020/21
No. of deaths	289	176	294	391
No. of deaths reviewed by Medical Examiner†	100%	100%	95%	82%
No. of investigations (% of total)	20.4%	31.8%	18%	20.7%*
No of Coroner Referrals (% of total)	25.25%	29.5%	21.8%	16.1%
No. of deaths with Care Quality concerns (%)	1	1	0	0
No. of potentially avoidable deaths (%)	1	1	0	10**

† All deaths reviewed by Medical Examiner Scrutiny process – During the second wave due to staff redeployment and numbers of deaths, the Coronavirus Act was put in place to manage the excess deaths in the hospital. This reduced the number of deaths that had Medical Examiner Scrutiny

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

*** on the basis that these patients died 'of COVID' (listed under Part 1 of the medical certificate of cause of death, MCCD) having 'definitely' acquired COVID in the hospital (diagnosis >14 days following admission).*

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 2021/22, medical examiners will continue to work to increase the proportion of cases in which they identify potential care quality concerns in order to feed into the structured judgement review process.

2.10 Seven Day Services

The 7 Day Service (7DS) standards have been defined by NHS England and focus upon the care provided to patients admitted to hospital on an emergency basis.

The ten standards are divided into four priority standards and six others. It was expected that organisations were compliant with the priority standards by April 2020, although the onset of the COVID-19 pandemic inevitably reduced focus on this area.

At MKUH, work on the 7DS standards is led by the Medical Director's Office. Progress against the four priority standards has been measured through data arising from a weekly audit of 60 randomly selected patients discharged following an emergency admission in the prior week. These audits have not been routinely conducted during 2020/21, although an audit in April 2020 did demonstrate improved compliance with standard 8 (which will have been in part a function of revised medical staffing rotas in view of the emerging pandemic).

The Medical Director's Office is due to restart the regular audits in the near future and will report on performance from Q3 of 2021/22.

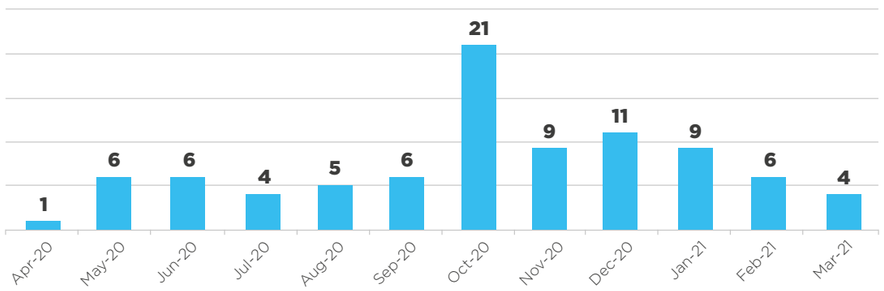
2.11 Report by the Guardian of Safe Working Hours

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

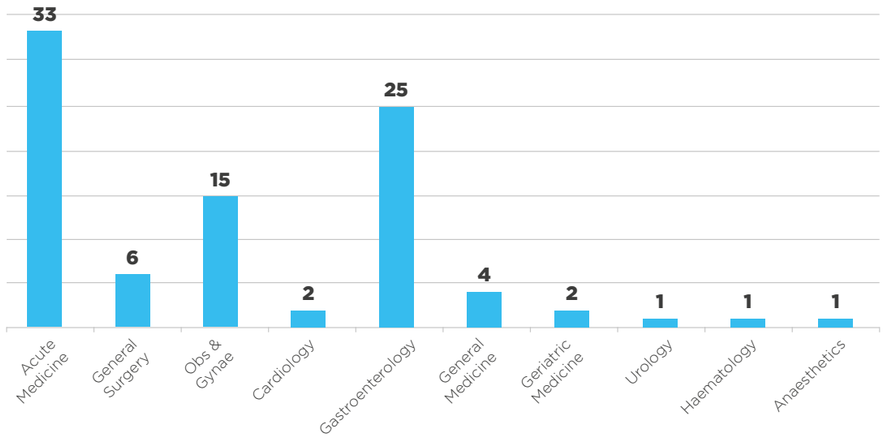
Exception reporting is the process where a trainee doctor can raise issues with their educational supervisor in relation to one or more of: their hours of work; the level of support offered to them by senior colleagues; or training opportunities which vary significantly from those described in their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

During the financial year 01 April 2020 – 01 March 2021 the following exceptions have been reported:

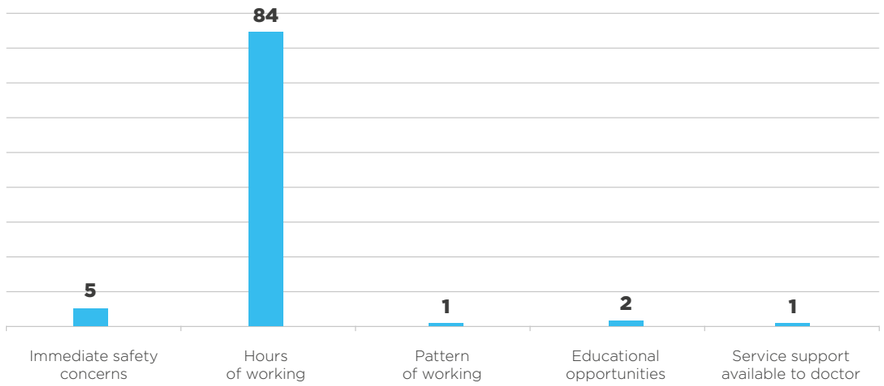
Exception reports by month



Exception reports by department



Reasons for exception reporting



Reports peaked from October to December with 49% (53) of the entire year's exceptions being raised in these three months alone. Most exception reports were raised by FY1 trainee doctors in Acute Medicine and FY2 doctors in Gastroenterology. The peak in the Gastroenterology department was due to staff shortage at the registrar level, which was identified, and changes were promptly made.

The acute medicine peak was mainly due to staff shortages during second wave of COVID-19 for multiple issues (e.g., COVID sickness, self-isolation) and, an increased number of acutely unwell patients across medical wards.

96% (104) of reports relate to hours exceptions and 1.85% (2) to educational issues, 0.93% (1) to service support and 0.93% (1) due to work patterns.

2.12 Opportunities for Members of Staff To Raise Concerns Within The Trust

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

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

Of the routes for speaking 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. By the beginning of March 2021 MKUH had recruited Freedom to Speak Up Champions and has a lead Guardian plus four five other Guardians. The lead Guardian plans to recruitment further Guardians and 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 / Champions and ensures that confidentiality anonymity is afforded to those individuals as a matter of course. Anonymity is possible and for all witnesses we strive to ensure that they are protected from detrimental behaviour 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 Champions (telephone number and email address). Feedback is given directly to colleagues who raise a concern and, in-turn, feedback received from those making disclosures indicates that the facility to raise their concerns and have them heard, often for the first time, has been beneficial.

In the period April 2020 to March 2021 there has been six cases recorded and reported to the National Guardians Office. This is a modest increase in numbers on the previous 12 months. The Lead Guardian is using the regional Guardians group and other resources to seek ideas to improve the uptake of the Guardian service. Staff who have spoken up in the past have not reported any detriment to them for doing so.

During the same period, there were 1118 contacts made to the Trust's informal and confidential P2P (Peer to Peer) listening service.

The current Lead Guardian has had opportunities in 2020-21 to speak to Catering managers, and newly recruited Healthcare Support workers. Further opportunities to raise the FTSU profile are being developed. This will be helped by the Trust offering Guardians allocated time for FTSU activities.

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

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

2.13 Reporting Against Core Indicators

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

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

a) The national average for the same; and

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

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

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

SHMI Table

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

The Summary Hospital-level mortality (SHMI) reports at Trust level across the NHS using a standard and transparent methodology. SHMI has a lag presentation time period of 6 months. The Trust's SHMI remains at statistically 'as expected'.

The Trust remains committed to monitoring the quality of care through mortality review processes to identify themes, areas for improvement as well as good practice. Our aim is to create a learning environment from deaths. All deaths at MKUH are reviewed by the independent Medical Examiner.

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

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

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

During 2020/21 the Trust made effective use of eCare, its electronic patient record system to simplify the data collection process.

NB; Due to the Trust's response to the COVID-19 pandemic, VTE Assessments were suspended in 2020/21.

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

24. Domain of Quality	Level	2016/17	2017/18	2018/19	2019/20	2020/21
Rate of C.difficile infection (per 100,000 bed days)	**MKUHFT**	6.0	7.1	8.6	5.1	Not Available
	National	13.2	13.6	12.2	13.6	
	Other Trusts Low/High	0 / 82.6	0 / 90.4	0 / 79.8	1 / 51.0	

NB: Due to the impact of COVID-19 national data for 2020/21 is not yet available from NHS Digital.

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

There were 7720 patient safety incidents reported in 2020/21, which equated to 70.22 incidents per 1,000 bed days. This is from the 8357-patient safety incident reported in 2019/20, which equated to a reporting rate of 51.64 incidents per 1,000 bed days. Of the incidents reported in 2020/21 28 (0.36%) were categorised as Major/ Catastrophic, compared to the 26 incidents (0.31%) which were categorised as Major/ Catastrophic in 2019/20. It should be noted that the COVID-19 pandemic resulted in a significant reduction in the number of inpatients (due to the reduction of non-emergency admissions), which resulted in a significant increase in the reporting rate per 1,000 bed days.

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

e. Responsiveness to Inpatient Needs

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

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

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

Domain 4: Ensuring that people have a positive experience of care						
20. Domain of Quality	**Level**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Staff who would recommend the trust to their family or friends	**MKUHFT**	69%	66%	68%	Not Available	Not Available
	National	65%	70%	70%		
	Other Trusts Low/High	48% / 91%	47% / 89%	41% / 90%		
Patients who would recommend the trust to their family or friends (Inpatient FFT - February in each year available)	**MKUHFT**	96%	97%	96%	Not Available	Not Available
	National	96%	96%	96%		
	Other Trusts Low/High	76% / 100%	82% / 100%	76% / 100%		

3

Other Information

3.1 Patient Experience

3.1.1 Complaint Response Times

The total number of complaints received for 2020/21, at the time of reporting totalled, 829. When compared to 2019/20 this amounts to a reduction of 32.4% (2019/20 n= 1227).

All complaints are triaged by severity upon receipt. The number of complaints received by severity for 2020/21 is detailed below:

Red - Severe harm	0
Amber - Moderate Harm	157
Yellow - Low Harm	645
Green - No Harm	27

In percentage terms, the number of no and low harm complaints amounts to 81% (73% 2019/20) of total complaints received.

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

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

The total number of complaints received for 2020/21, at the time of reporting totalled, 829. When compared to 2019/20 this amounts to **a reduction of 32.4%**

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

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

To ensure that complainants are provided with a timely response to their complaint and investigations are undertaken in a timely manner, the Trust has set its own internal timescales for dealing with complaints and these are set at; 60 working days for severe harm (red), 30 working days for moderate harm (amber) complaints, and 15 working days for no and low harm (yellow and green) or within the 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 91%.

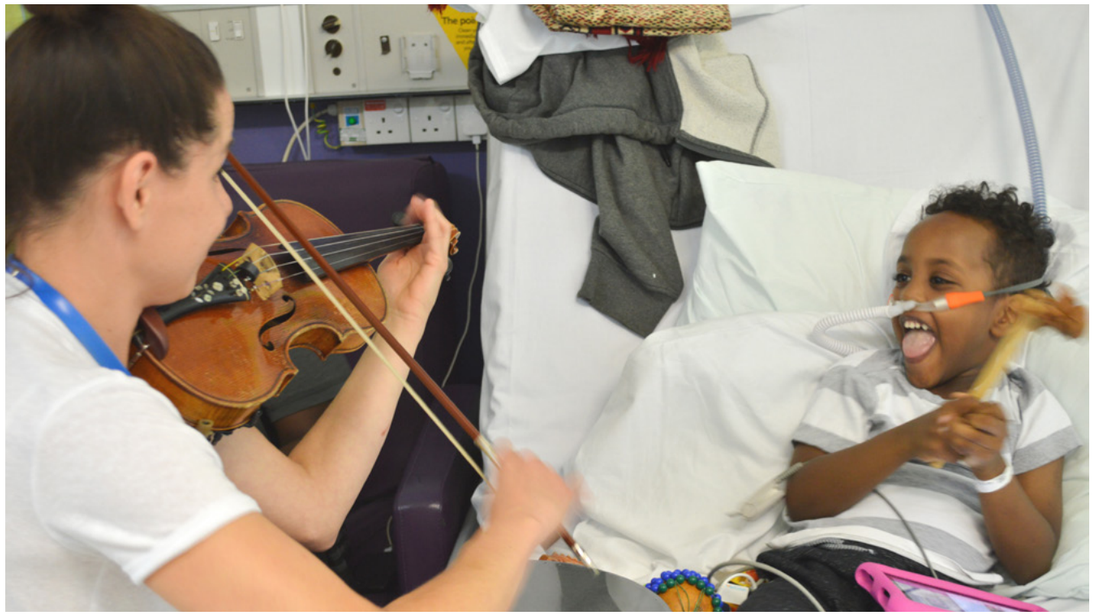
The achievement in performance in relation to reaching the target set has occurred as a result of a robust escalation process being in place. This ensures, at an early stage, that late investigation responses are highlighted to the senior divisional team and the Executive Directors, if necessary. A weekly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

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. At the time of writing, information is only available for quarters 1 and 2 2020/21.

TRUST	Q1- Written complaints	Q2 – Written complaints
MKUH	113	147
Northampton Hospital	41	56
Buckinghamshire Health Care Trust	101	150
Bedford Hospitals	103	185



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 (DOC) requirements and looks to advise/include patients and/or next of kin in investigations.

The Trust incident reporting policy outlines 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 2020/21 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 2020 – 2021 which related to:

October 2020:

Concern expressed that a baby's death might have been prevented had a routine screening programme for Group B Streptococcus (GBS) been in place for expectant mothers, with reference to screening programmes in place overseas and an advocate of the setting up of such a screening programme in Milton Keynes.

The Trust response noted that the that the Royal College of Obstetricians and Gynaecologists does not currently advocate routine screening, and that July 2020 HSIB report on this matter found no evidence that intrapartum antibiotics prevent late onset GBS. The Trust also highlighted that screening is coordinated centrally through the UK National Screening Committee (UK NSC), and bespoke local programmes are ordinarily only supported where the community prevalence of a disease is known to be much higher than the national picture.

Agreed Trust actions were:

1. Explore the potential of our Electronic Patient Record (eCare, Cerner) to alert healthcare professionals to mothers who have had a history of GBS in the current or previous pregnancies.
2. Make further enquiries about the multi-centre trial referred to in the HSIB report (GBS3, University of Nottingham) and look into the potential participation of the BLMK local maternity system (LMS) in this study. MKUH had previously approached the University of Nottingham with a view to becoming a trial site but unfortunately at that time, the trial was only seeking larger units (in terms of deliveries per annum).

March 2021:

The patient attended the Emergency Department (ED) on the 03/10 and 04/10 following advice from 111 as he had been complaining of persistent vomiting. On both occasions he was given anti-sickness tablets and discharged home. His pain continued as did his vomiting and passing blood. On the 08/10 he was found him slumped on the bathroom, unresponsive and in a pool of blood. Paramedic confirmed death at 00.34hrs on the 09/10/19. Post-mortem gave cause of death as 1a) Acute Bowel Ischaemia 2) Duodenal Ulcer, Ischaemic Heart Disease.

During the course of the inquest the Coroner considered that this meant that under the NICE guidelines the patient should have had his lactate reading taken again following his bolus of fluid which did not happen and saw this as a systemic issue.

The Trust's letter of response has since been sent advising of the following three actions:

1. Ensure the Trust sepsis policy is up to date by November 2021
2. Repeat an audit locally on the management of patients with suspected sepsis against the 8 RCEM standards
3. Consider the case for the designation of a sepsis lead within the department with specific responsibilities for ensuring that the profile of sepsis remains high

3.2.3 Serious Incidents (SIs) & Never Events

The Trust reported 1 Never events in the year 2020 – 2021; a wrong side bearing inserted during uni-condylar knee surgery.

The Trust reported 92 SIs in the year which can be broken down as follows:

SI Category	Number of incidents
Pressure Ulcer	24
Delayed Diagnosis	19
Sub-optimal care of the deteriorating patient	6
Drug Incident (general)	13
Surgical error	2
Slips, Trips, Falls	3
Maternity Service - Unexpected admission to NICU	7
Maternity Service	4
Maternity Service - Intrauterine Death	1
Medical Equipment Failure	1
Safeguarding Vulnerable Adult	1
Unit Closure	2
Attempted suicide of an inpatient	1
C diff/healthcare acquired infection	1
Communication	1
Failure to act on test results	1
Safeguarding vulnerable child	1
Venous thromboembolism (VTE)	2
Unexpected death	1
Total	**92**

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 2020/21 were:

- Deep tissue injury to patients' heels and failures to accurately assessment/document skin damage
- The impact of COVID-19 on patient's skin integrity (noted as a national issue)
- The increase in patient falls compounded by isolation requirements of COVID affecting patient visibility
- Increase in the number of violence and abuse incidents (both physical and verbal) and the psychological impact on staff. Working party since established in the Trust
- Medication incidents for missed/delayed doses (especially for critical medications in diabetes and Parkinson's Disease).
- Intravenous (IV) medication incidents with ongoing work relating to the process of second checks
- The significance of a no blame, learning culture and the importance of speaking out
- Major obstetric haemorrhage/ post-partum haemorrhage (MOH/PPH). Maternity Review Group now in place to assess individualised criteria including the case situation and impacts within the management of the PPH/ MOH which had the potential, if approached differently, to reduce the impact on the woman and her recovery

The Trust commenced case reviews of COVID-19-related deaths, associated with possible nosocomial hospital transfer to ensure Duty of Candour requirements were met with the families & that the Trust was open & transparent with families and HM Coroner (as required). The 4 categories (based on national criteria) for determining whether a COVID-19 infection was hospital acquired or not were:

- Community acquired - If a patient is screened on admission/ or within the first 48hours or has COVID-19 symptoms and is tested positive
- Hospital onset indeterminate healthcare associated – positive specimen date 3-7 days after admission, with no prior hospital admission in the previous 14 days
- Hospital onset probable healthcare associated – positive specimen date 8-14 days after admission or a specimen date 3-14 days after admission in previous 14 days
- Hospital onset definite healthcare associated – positive specimen date 15 days after admission

Learning is shared in local and Trust-wide newsletters and governance reports for clinical improvement meetings (CIGS), with escalation reports to corporate governance committees. A Quality Learning and Improvement Board was established with the aim of ensuring that areas that require improvement are being addressed through quality improvement (QI) and to monitor improvement through feedback once projects are implemented. With the impact of COVID-19 affecting usual learning forums, the Trust introduced webinars on Microsoft Teams that staff could access on key learning points and held regular virtual forums to share information with staff. The Trust also has the Greatix system for sharing learning and congratulating individual staff.

3.2.4 Midwife to Birth Ratio

Midwives are present at all births and are the main providers of antenatal and

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

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

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

Month	Midwife to birth ratio
April 2020	1:26
May 2020	1:27
June 2020	1:26
July 2020	1:31
August 2020	1:28
September 2020	1:28
October 2020	1:28
November 2020	1:31
December 2020	1:24
January 2021	1:25
February 2021	1:27
March 2021	1:27

3.2.5 Statutory and Mandatory Training

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

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

MKUH Mandatory training competencies are mapped to the Core Skills Training Framework

There has been a steady improvement in statutory and mandatory training – the table below shows the compliance rate by year and at the end of each quarter.

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

Mandatory training is reported at Workforce Board, Workforce and Development Assurance Committee (quarterly) and Trust Executive Group (monthly). During 2020 ESR self-service has been developed with all training except Manual Handling (Level 2) and Resuscitation now accessible via its e-Learning platform. The Trust consequently no longer uses workbooks routinely and the movement to e-Learning has been of particular timely use during the pandemic. The Trust has also adopted use of the national principles of the pay progression framework to support increasing levels of compliance into 2021/22.

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.

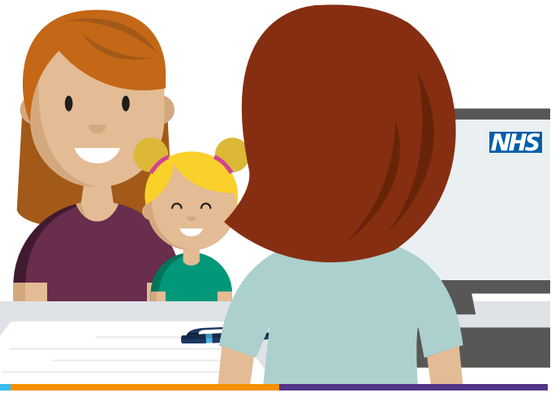
Milton Keynes University Hospital has developed services to ensure live access for the Multidisciplinary teams to all cancer performance targets and a live patient tracking tool to enable management of patient's pathways and early identification of delays and trends of issues. There are weekly escalation 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 Milton Keynes (MK) CCG 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 MK CCG report the cancer positions back through their Board meetings.

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

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



62-day Cancer Performance

Tumour Site	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Brain												
Breast	73.3%	66.7%	87.5%	100.0%	90.9%	100.0%	87.5%	92.9%	72.7%	84.6%	71.4%	93.1%
Colorectal	0.0%	0.0%	25.0%	42.9%	44.4%	50.0%	50.0%	63.6%	57.1%	61.5%	53.3%	33.3%
Gynaecology	0.0%	66.7%	25.0%	33.3%	100.0%	40.0%	7.1%	0.0%	100.0%	100.0%	33.3%	66.7%
Haematology	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%
Head and Neck	33.3%	66.7%	66.7%	100.0%	100.0%	40.0%	22.2%	100.0%	0.0%	0.0%	100.0%	80.0%
Lung	0.0%		50.0%	80.0%	100.0%	92.3%	37.5%	33.3%	66.7%	100.0%	28.6%	28.6%
Other							0.0%					
Skin	100.0%	76.9%	97.7%	92.9%	100.0%	100.0%	97.0%	100.0%	94.7%	96.8%	96.3%	100.0%
Upper GI	100.0%	33.3%	100.0%	66.7%	100.0%	77.8%	63.6%	75.0%	90.9%	100.0%	0.0%	66.7%
Urology	87.0%	81.8%	90.9%	60.0%	88.0%	82.9%	72.2%	78.8%	86.2%	85.7%	82.8%	66.7%
Grand Total	**75.9%**	**62.0%**	**81.4%**	**77.7%**	**90.0%**	**84.2%**	**67.3%**	**81.6%**	**81.3%**	**86.1%**	**73.3%**	**77.2%**
Including Rarer Cancers (RC)	**75.9%**	**64.3%**	**81.4%**	**78.0%**	**90.2%**	**84.4%**	**67.8%**	**82.1%**	**81.3%**	**86.3%**	**74.5%**	**77.2%**

3.3.2 Long waiting patients

Due to the impact of the COVID-19 pandemic on the Trust's clinical operations, the number of patients who have waited for 52 weeks or more on the waiting list increased from 0 in April 2020 to 1,073 in March 2021. Providing care to patients in a timely manner is a key element of the high-quality services the Trust seeks to offer, and as the hospital recovers from the response to the pandemic, our aim is to return to the position of having no patients at all waiting a year for their planned treatment.

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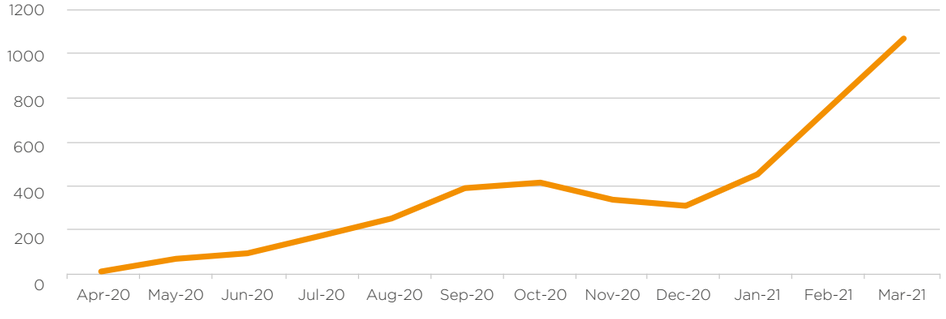
Number of >52 week waiters on RTT waiting list at MKUH



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 Quality Improvement (QI) team temporarily redeployed in February 2020 to focus on COVID-19 roles, the pandemic 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.

Since the end of the redeployment, the team structure has changed following the creation of the two Patient Safety Lead roles, who maintain a quality improvement remit within their roles. The current QI team consists of two part time staff members, linking with the wider clinical governance team, Nursing Quality Team, and Trust Audit Lead.

In recognition of the role of QI in enabling effective governance and quality assurance, the remit of the team includes:

- Development and embedding Quality Improvement across the Trust
- Lead on the Implementation of the Appreciative Inquiry Approach
- Establish a reporting framework for capturing, celebrating and sharing improvement activities, including audit
- Creation of an Improvement Hub and network to enable staff to access the range of tools, and resources for improvement of safety, effectiveness and experience
- Provide and deliver a range of training on improvement methodologies including access to external online courses, as well as face to face
- Ensure for 2021-22 the audit programme is interlinked with QI programmes and uses QI methodologies as appropriate, for implementation of recommended actions and improvement
- Provide recommendations for the Trust Quality Priorities, supporting delivery as required
- GIRFT:
  - Collate quarterly specialty implementation plan updates and submit to National GIRFT Team by the end of the financial quarter.
  - Produce a quarterly highlight report to the Transformation Programme Board.
  - Maintain regular meetings with operational and clinical leads to review progress, and provide support and training where required.

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

Improvement Work 2020-21:

A review of the Improvement work across MKUH identified that both despite and because of COVID-19, improvement work has continued through the use of formal QI methodologies (e.g. PPE, Oxygen Stewardship, Pharmacy, Cardiology projects), and informally with the need to make rapid changes to service delivery (e.g. ED streaming, service relocation).

It has also become clear that there are different approaches to improvement being used across the Trust with associated training being provided. This includes QI (Model for Improvement), Appreciative Inquiry (AI), Human Factors, Simulation Training, Audit, Research and Development. This therefore provides an opportunity for a coordinated approach, and to provide staff with best practice tools, skills and a network of staff with skills to help and facilitate.

The Improvement Hub and Network:

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

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

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

It is envisaged that a physical Improvement Hub space will be re-established once the COVID-19 restrictions are removed, with the opportunity for the wider Improvement team to be able to work more closely together.

Celebrating Success:

The sharing of improvement work being completed is essential to encourage more, therefore the annual audit award is being re-framed to become the Annual QI and Audit award. This will be accessible for all clinical and non-clinical staff to get involved. An improvement wall is being created where staff can have their improvement posters displayed and shared, presentations will be given in October 2021.

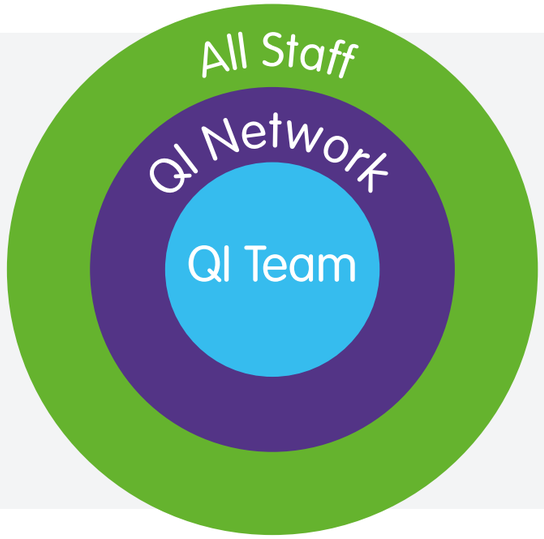
The Improvement Network:

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

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

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

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



Training:

Prior to the pandemic and ceasing of non-essential training, the QI team facilitated QI training modules as part of existing leadership programmes to 110 members of staff. Individual and team-based support/workshops were and continue to be provided.

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

Staff are therefore being directed to the online QI methodology training provided by Future Learn, NHS Elect and NHSE&I, and provided with coaching and support from the QI team in using these tools in their improvement work at a team and individual level.

The Trust leadership programme (with QI modules within them) are due to be recommence in September 2021 (subject to COVID-19 restrictions).

To shape the training, all staff who have previously attended QI training and any online training will be contacted to feedback on the effectiveness, to provide the opportunity to improve delivery. A Task and Finish Group is being established to review and agree on the next approach and whether a blended approach including QI, AI and Human Factors would be of benefit.

Reporting:

The QI team together with clinical governance has commenced a project to review and refresh the governance reporting to facilitate delivery of measurable improvement (including GIRFT and Audit) and learning.

This is being piloted in ED, and subject to feedback, its envisaged this will be rolled out at a Clinical Service Unit (CSU) and Divisional Level through 2021/22.

AI Programme 2020-21:

The aim of the programme is to develop and grow a culture that fosters appreciation, curiosity, meaningful engagement, co-creation and innovation that will lead to enhanced relationship centred practices across the organisation. This will enhance the experiences of staff, patients, and families and make MKUH a leader in whole system development based on what matters to all of us.

AI Programme Delivery November 2020-April 2021: Workshops and in practice work

The AI programme commenced in November 2020 as a pilot in the Maternity Unit, a key area in the organisation.

Close work with 16 members of the Maternity Team was provided via face-to-face workshops and in practice work to support development of leading appreciative inquiry in November and December 2020.

A follow up workshop with the November 2020 Maternity Team attendees will be held in April 2021, with a further workshop with 12 new members of the multidisciplinary team from Maternity including consultants, nursery nurses, pharmacists, midwives, practice development staff and communication lead for patient experience and quality improvement.

Resources and Information:

There is a plan to develop an AI area on the Trust intranet with resources to help bring AI to life. These will be branded as MKUHT resources and with appropriate attribution credited to the developers. This Hub will contain over 25 resources that enhance dialogue with staff, patients and families to learn about what is working well and why, and what matters to people to co-create future quality improvement initiatives, however small. This has been supported by members of the library and quality improvement team.

Systems, Processes and Sharing

New appreciative systems and processes to align with appreciative inquiry principles which will be piloted in 2020/21 include:

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

3.4 Performance Against Key National Priorities

Indicator	Target and source (internal / regulatory / other)	2018/19	2019/20	2020/21
Maximum waiting time of 31 days from diagnosis to treatment for all cancers*	96% (National)	99.2%	98.0%	94.5%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers*	85% (National)	83.9%	81.1%	78.5%
Maximum wait of 2 weeks from GP referral to date first seen for all cancers*	93% (National)	96.4%	94.3%	84.1%
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments*	98% (National)	100.0%	99.0%	98.3%
Maximum waiting time of 31 days for subsequent cancer treatments: surgery*	94% (National)	98.9%	98.6%	84.2%
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients*	93% (National)	96.4%	97.5%	92.1%
Referral to treatment in 18 weeks - patients on incomplete pathways**	92% (National)	87.4%	85.5%	57.8%
Diagnostic wait under 6 weeks**	99% (National)	98.7%	98.9%	83.2%
A&E treatment within 4 hours (including Urgent Care Service) **	95% (National)	91.4%	88.8%	93.1%
Cancelled operations: percentage readmitted within 28 days**	95% (National)	70.4%	86.5%	50.0%
Clostridium difficile infections in the Trust**	39 (National)	15	14	6
MRSA bacteraemia (in Trust) **	0 (National)	1	0	1
Indicator	Target and source (internal / regulatory /other)	2018/19	2019/20	2020/21

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