TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

MKUH Quality Report

2022/23

Contents

1 The Quality Account

1.1 Introduction

Milton Keynes University Hospital NHS Foundation Trust (referred to as 'MKUH' or 'the Trust') is a district general hospital providing a broad range of general medical and surgical services, including Emergency Department (ED), 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:

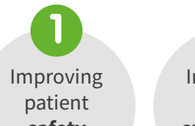
1. Improving patient **safety**
2. Improving patient **experience**
3. Improving clinical **effectiveness**

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 Milton Keynes, 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 Healthwatch Milton Keynes and various patient participation groups.

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

This Quality Account 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.



We**CARE**

We**COMMUNICATE**

We**COLLABORATE**

We**CONTRIBUTE**

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

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

One of the requirements in compiling the Quality Account for the previous financial year (2022/23) is to select at least three quality priorities for the year ahead (2023/24). These priorities are included in Part 2 of the Quality Account.

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 Account must indicate how the priorities will be met, monitored, measured and reported by the Trust. The Quality Account provides an evaluation of progress in meeting the quality priorities set for 2022/23 and gives a general overview and evaluation of how well the Trust has performed across a range of quality metrics throughout the year.

1.2 Statement on Quality from the Chief Executive

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

The Quality Account provides us with a chance to look back on how we improved our quality of care provided to patients throughout 2022/23, and where there are opportunities to make further improvement moving into 2023/24 and beyond.

As with 2021/22, this Quality Account is different to that published in normal years because it continues to reflect some of the significant effects of the COVID-19 pandemic, which reached the UK in March 2020 and has presented significant challenges ever since, making conditions very difficult for everyone working in and using healthcare services. As ever, our staff have worked incredibly hard to maintain services during this very difficult period for all.

One of those difficult areas has been the introduction of visiting restrictions, which we know have taken their toll on patients, families and staff. Throughout the pandemic, restrictions were introduced to reduce footfall across the site, in order to reduce transmission of COVID-19. While we were able to relax visiting restrictions in February 2023, for several months of the year we unfortunately had to restrict the majority of our adult inpatient areas to one visitor, although mobile devices in wards have helped patients to keep in contact with loved ones virtually. We thank all patients and visitors for their understanding and cooperation with this policy which, whilst not ideal, has helped us to minimise the spread of the virus across the site of the hospital.

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 by making these objectives the driving force behind everything we do as a hospital. All our quality performance indicators are published at every Trust Board meeting so 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.

One of the achievements during 2022/23 was the Trust's continued use of technology to improve quality of care and patient safety. At MKUH, technology is seen as a way to not only improve the services provided to patients, but also as a way to support our staff in the delivery of care and treatment. MKUH now offers patients the simplicity and reassurance of using their single, secure NHS login to access their MyCARE patient portal in a move which sees the hospital become one of the first in the country to offer such an option, supporting the organisation's success in unlocking the cost-savings and efficiency that comes with converting patients to digital access. Also on the technology front, the Versius surgical robot has now completed its 500th case, which is a wonderful landmark and continues to demonstrate MKUH's position as one of the national frontrunners in the area of robotics in the treatment and care of patients, helping to deliver very high levels of surgical precision and control by surgical staff. Milton the robot was another welcome addition to the Trust, helping to support some of our teams with the movement of goods across the hospital, thanks to some fabulous joint working between the Trust and the Academy of Robotics, a small British artificial intelligence company. We have also rolled out the mobile version of the Friends and Family Test platform to the rest of the Trust, making it available across all areas of the hospital, including for paediatric patients, and this has increased feedback significantly, allowing us to better act on what our patients and visitors think of their experiences of the hospital and, ultimately, helping to improve the experiences of future patients and visitors.

The new Maple Centre, which opened in October 2022, has helped to improve the quality of the treatment and care that our staff provide, providing dedicated space for both medicine and surgical Same Day Emergency Care (SDEC) pathways to the population of Milton Keynes. The unit improves access to hospital services for primary care provides a central facility to provide senior clinical input for patients with ambulatory sensitive conditions and the frail elderly; reduces reliance on escalation areas providing better care for patients; and avoids avoidable admissions Upstairs in the new centre, there is a 26-bed ward which provides specialist care for those patients who require additional treatment.

I was delighted to see construction work is already underway on the new Radiotherapy Centre, which is to be located adjacent to the Cancer Centre. Given the significant need for such a facility for the communities of Milton Keynes and beyond, the Trust has moved quickly to begin building work, and this will complete the offering of cancer services available at MKUH, improving access to healthcare for Milton Keynes residents. The new facility is set to open to patients in summer 2024.

With the Milton Keynes population one of the fastest growing and most diverse in the UK, and with the Trust experiencing unprecedented levels of demand for its services, against a backdrop of the NHS backlog and the cost of living crisis, it is vitally important our hospital continues with the expansion and improvement of its services, facilities and infrastructure, in order to meet the ever-changing needs of our communities. These service improvements will help to further improve the quality of our treatment and care to patients, enabling us to achieve our objectives in line with our responsibilities to the development of Milton Keynes as a city, and we will continue to work with our partners and engage with the public in order to deliver on these.

The year of 2022/23 was very challenging for the communities of Milton Keynes and beyond, but with the continued dedication and hard work of our staff and volunteers, we are able to move into 2023/24 with a great deal of positivity and optimism.

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.

Joseph Harrison
Chief Executive

27 June 2023

2

Priorities for Improvement and Statement of Assurance from the Board

2.1 Priorities for Improvement in 2023/24

This section of the Quality Account describes the areas we have identified for improvement in 2023/24. In March 2023, these priorities were shared with and agreed by our Quality and Clinical Risk Committee and Council of Governors – a body made up of elected members of staff, members of the public and nominated stakeholder representatives.

The plan is to realign the 2022/23 priorities, continuing one aspect for a third year as it, priority one, aligns with the Trust's operational priorities and wider national ambitions, and to select other safety and effectiveness priorities based on current safety and clinical effectiveness data.

The first priority, reducing deep tissue injuries – also called pressure ulcers - is an area that has the potential to provide significant improvements in patient safety.

The second priority, improving sepsis management, will improve the effectiveness of the treatment of patients.

The third priority, improving reporting rates of low harm events, will improve patient safety and also improve the experience of patients while providing them with effective of treatment.

1 Priority 1: Reduction in deep tissue injuries (pressure ulcers)

Why have we selected this priority?

Deep tissue injuries have a significant impact on patient outcomes and wellbeing and therefore remains one of our key quality priorities. Deep tissue injury is damage to the skin where the depth is unknown, the blood flow to the area is diminished and therefore is likely to be deep damage occurred.

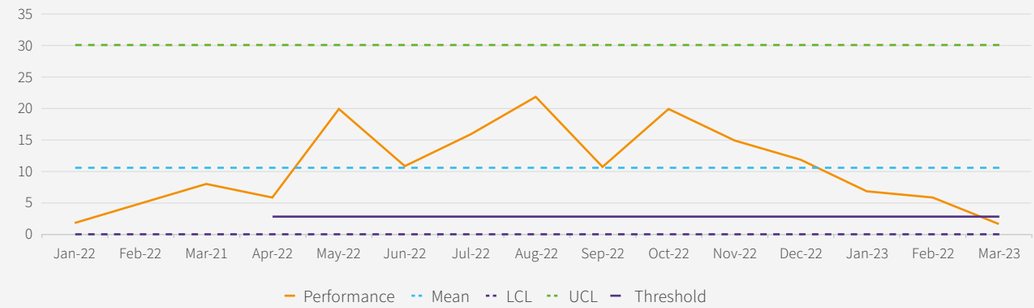
Reducing deep tissue injuries has remained a quality priority for a third consecutive year. This is to ensure continued focus in the reduction of deep tissue injuries and because the categorisation and capture of deep tissue injuries changed between the 2021/22 and 2022/23 reporting years – contributing at least in part to a marked increase in documented incidents of deep tissue injury. This makes year-on-year comparison more challenging, and a continued focus into 2023/24 using the same categorisation and capture of deep tissue injuries will ensure that the reduction noted from October 2022 continues.

What is our past performance in this area?

In the 2022/23 period, there were 148 Deep Tissue Injuries (DTI). Of these, 50 occurred in the Surgical Division, and 98 were reported in Medicine. All incidents were reported through the Trust RADAR reporting system, and a thorough Root Cause Analysis investigation was conducted, including thematic reviews. The insights gathered from these reviews were utilised to create a Trust-wide Quality Improvement (QI) Programme implemented in December 2022. The QI programme focuses on Education, Care Standards, Infrastructure and Culture, and Patient/Family involvement. The Trust Harm Prevention Group monitors and reviews the QI programme monthly.

Moreover, the number of reported DTIs steadily decreased from October 2022 until the end of the reporting period in March 2023. In January 2023, the Trust introduced a revised process to review and confirm the category of DTIs once the pressure damage had become visible or resolved.

2022/23 Pressure Ulcers Classification - DTI



How will we monitor and measure our performance in 2023/24?

The Trust will monitor, measure and improve its efforts to maintain high-quality pressure ulcer care and prevention through various groups, such as the Care Review and Learning Panel and the Trust Harm Prevention Group. These groups will identify patterns, share knowledge and best practices, and ensure they are applied across clinical areas and divisions.

How will we report our progress against achieving this priority?

The Trust will provide quarterly progress reports to the Patient Safety Board to ensure progress against improvement targets. Monthly reports to the Trust Board showing trends in pressure ulcer categories and by the number of beds, days will also be included. Furthermore, pressure ulcer rates will be monitored and discussed with each Ward during the monthly ward assurance process.

2 Priority 2: Improvements in sepsis management

Why have we selected this priority?

Sepsis has been selected as a priority to co-ordinate and focus improvement work on the identification, treatment, and management of sepsis. This includes focussed work in the Emergency Department as well as across admitting wards and departments – including maternity. This programme of work will include addressing Coronial recommendations and will involve patients and families to understand their experiences and the impact of a sepsis diagnosis.

What is our past performance in this area?

We have previously had focused sepsis programmes, including the launch of education and training materials. This saw improvement in awareness and identification of sepsis. This will be revisited in the 2023/24 improvement programme.

How will we monitor and measure our performance in 2023/24?

Developing metrics to accurately measure and assess performance sepsis care will form part of this improvement programme. Initially we will measure performance through a decrease in concerns raised around sepsis management through RADAR incidents, complaints and the Medical Examiner process.

How will we report our progress against achieving this priority?

We will report progress to the Patient Safety Board, Quality, Learning and Improvement Board and the Quality and Clinical Risk Committee throughout the year.

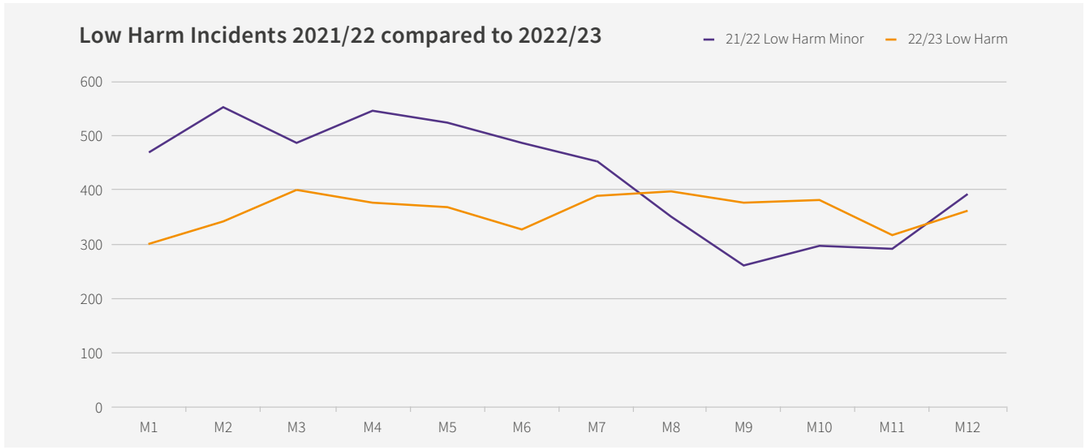
3 Priority 3: Improvements in the reporting rates of low harm events

Why have we selected this priority?

We have selected this as a priority to support improvement reporting culture – the reporting of low and no harm events enables the early identification of possible trends, triggering early intervention to prevent more serious harm occurring. As we implement the Patient Safety Incident Response Framework, we want to foster and promote the reporting of no and low harm and near-miss events, to maximise learning and feedback to reporters, and to ensure that early trends and clusters are identified and acted upon before more serious harm occurs.

What is our past performance in this area?

In 2022/23 4,363 low-harm events were reported in Trust, against the 4,671 low-harm incidents which were reported 2021/22. The graph below shows the reports on a month-by-month basis in 2021/22 and 2022/23.



How will we monitor and measure our performance in 2023/24?

The radar reporting rate will enable the Trust to monitor the volume of low/no-harm incidents reported. With the implementation of the new Patient Safety Incident Response Framework (PSIRF), in place of the current Serious Incident Framework, the focus will be improvement and learning which will link in with the Quality Improvement Programme. PSIRF is also more person focused placing the patient/staff at the forefront of investigations. Monitoring of progress and performance will be in line with the PSIRF plan as the Trust looks to roll out and embed this new process over the year. This new approach will mean see qualitative as well as quantitative data capture.

As part of PSIRF the Trust will be looking to identify its top key safety issues for focused investigation which may include low/no-harm incidents of significant volume and with potential for learning.

How will we report our progress against achieving this priority?

Overall, the Trust wants to see an increase in the number of incidents reported that are categorised as low/no-harm, with a reduction in recurring themes where possible. High reporting numbers are an indication of a positive reporting culture. Radar data will evidence this with reporting into the Serious Incident Review Group, Patient Safety Board. In addition, the embedding and success of QI projects linked to low/no-harm incidents will demonstrate the progress.

2.2 Our Performance against Priorities for Improvement in 2022/23

Priorities for 2022/23:

1 Priority 1: Reduction in deep tissue injuries (pressure ulcers)

Please see Priority 1 above for narrative on last year's performance – this priority continues into 2023/24 to maintain focus on reducing DTIs.

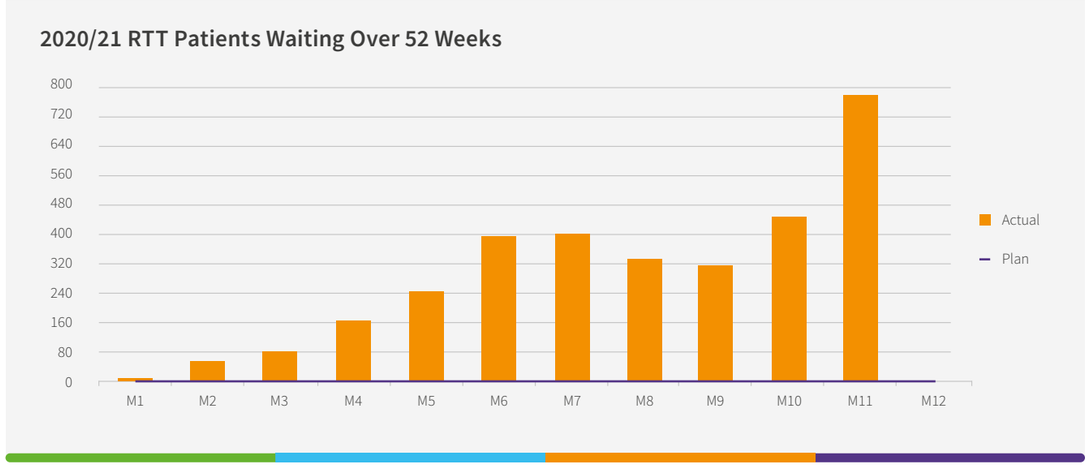
2 Priority 2: Improvements in (elective care) to reduce long waiting times

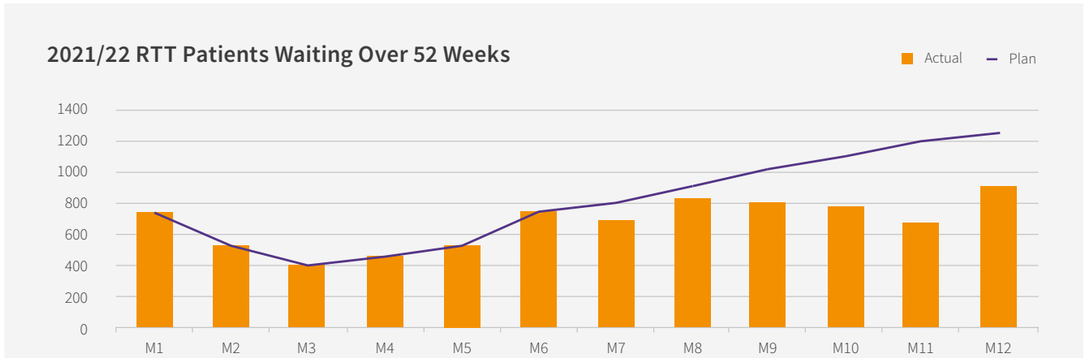
Why did we select this as a priority?

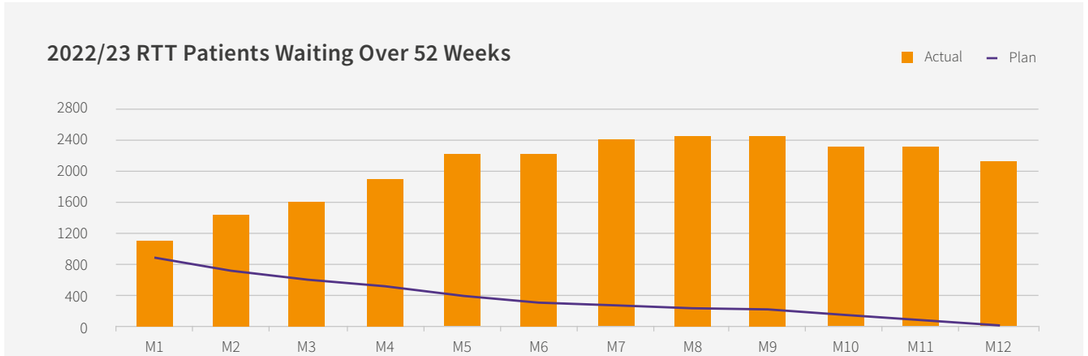
There had been a marked increase in elective waiting times since the start of the pandemic with much elective activity stood down during COVID-19 waves and patients delaying accessing their GP for referral into secondary care services. Reducing elective waiting times to pre-pandemic levels was a national priority, as well as a key priority for MKUH.

What was our performance in this area?

The charts below taken from Board Performance Reports show MKUH performance in elective patients waiting over 52 weeks through 2020/21, 2021/22 and 2022/23.







How will we monitor and measure our performance in 2023/24?

Performance in elective waiting times in 2023/24 will continue to be monitored through the monthly Board Performance Report, a key measure of elective waiting times is patients waiting over 52 weeks. Each division and specialty will also continue to monitor and review patients waiting over 52 weeks. Additionally, MKUH have set a suite of Quality Operational Priorities which includes a maximum wait time of 40 weeks for outpatient RTT patients.

How will we report our progress against achieving this priority?

Progress will be reported through the monthly Trust Board Performance Report, it will also form part of Trust national returns.

3 Priority 3: Reductions in discharge delays

Why have we selected this as a priority?

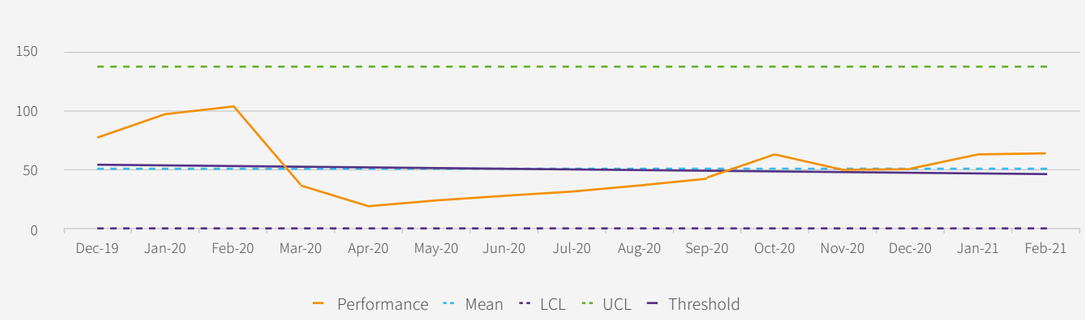
The number of patients we see in MKUH with a delayed discharge has increased since the start of the pandemic and is evidenced across a range of metrics. Reducing delayed discharges or reducing the number of patients who do not meet the criteria to reside in an acute hospital, is a national priority and remains key area of focus for MKUH.

Delayed discharges are where patients remain in hospital when no longer clinically required meaning that they are not in the most appropriate setting for their needs, whether that is at home, with or without additional support, in a care home, nursing home or other facility. They directly impact the bed availability for patients who do need acute care, contributing to ambulance handover delays, delayed admissions to a ward setting, the opening of escalation bed capacity and a dilution of hospital staff numbers to provide the care required.

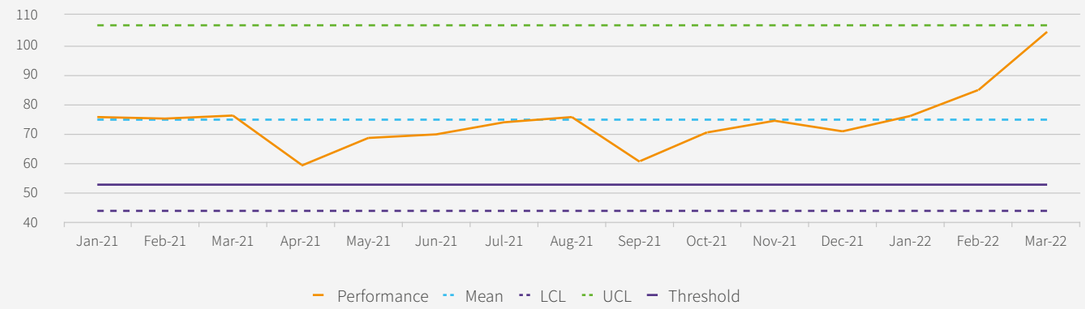
What is our past performance in this area?

The graphs below show the number of super stranded patients (with a length of stay >+21 days) and the number of delayed transfers of care through 2020/21, 2021/22 and 2022/23.

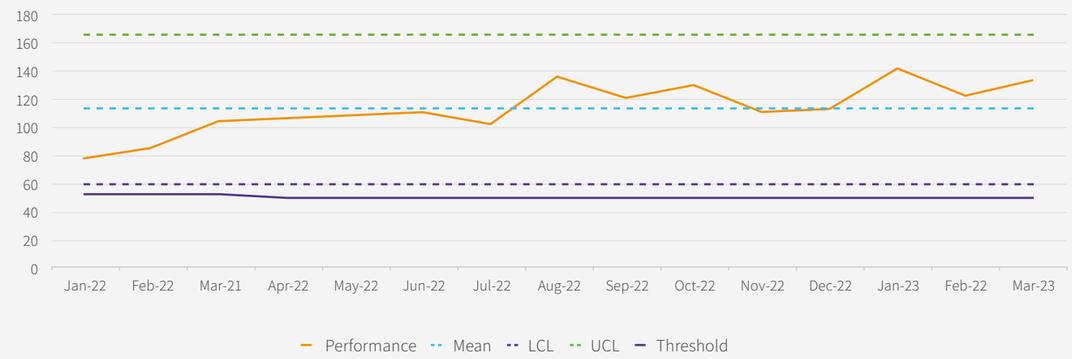
Number of Super Stranded Patients (LOS>=21 Days)



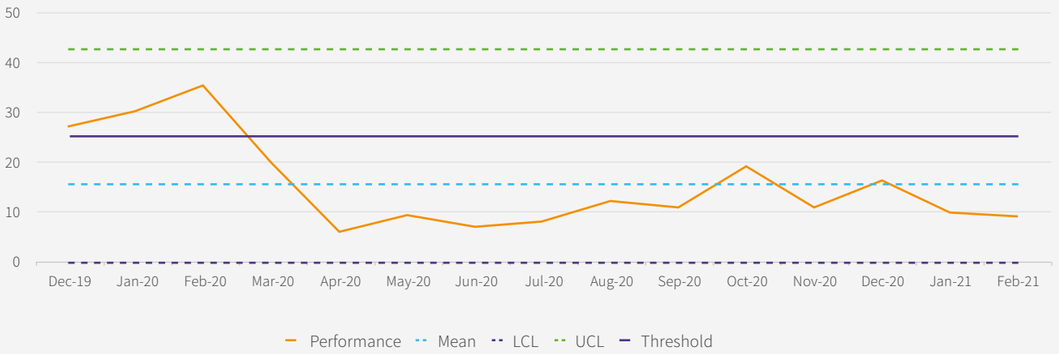
Number of Super Stranded Patients (LOS>=21 Days)



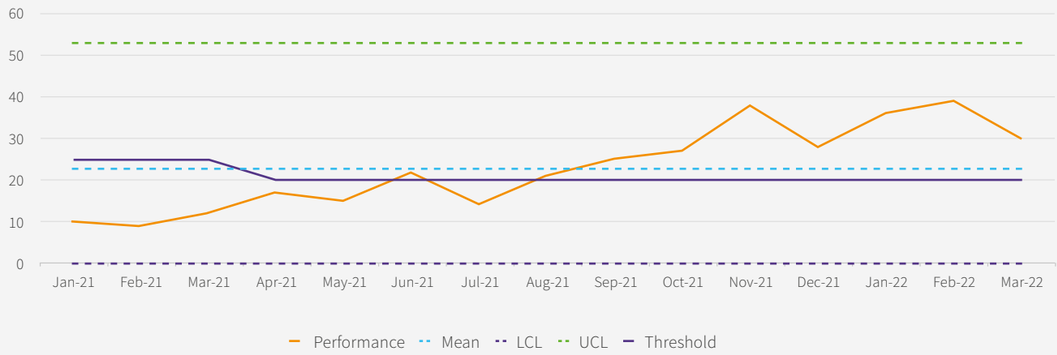
Number of Super Stranded Patients (LOS>=21 Days)

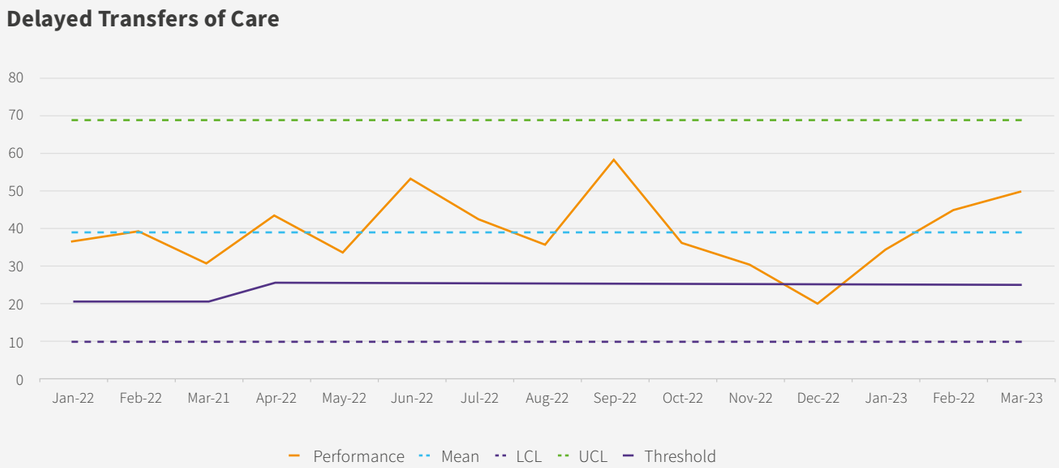


Delayed Transfers of Care



Delayed Transfers of Care





How will we monitor and measure our performance in 2023/24?

Performance in delayed discharges in 2023/24 will continue to be monitored through the monthly Board Performance Report, key measures are super stranded patients and delayed transfers of care.

How will we report our progress against achieving this priority?

Progress will be reported through the monthly Trust Board Performance Report, it will also form part of Trust national returns.

2.3 Statement of Assurance from the Board of Directors

During 2022/23 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 2022/23 represents 100% of the total income generated from the provision of relevant health services by Milton Keynes University Hospital NHS Foundation Trust for 2022/23.

2.3.1 Clinical Coding Audit

During 2022/23, 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 2022/23 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 2022/23 on 30 June 2023, having achieved 'Standards Met.'

2.4 Participation in Clinical Audits

Participation in Clinical Audits and National Confidential Enquiries

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

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

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

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

During 2022/23, we took part in 45 national clinical audits at Milton Keynes University Hospital and 3 national confidential enquiries.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2022/23 are shown in the tables below.

Programme count	Programme / Work stream	Participated at MKUH
1.	Breast and Cosmetic Implant Registry	Yes
2.	Case Mix Programme	Yes
3.	Child Health Clinical Outcome Review Programme	Yes
4.	Cleft Registry and Audit Network Database	No
5.	Elective Surgery: National PROMs Programme	Yes
6.	Emergency Medicine QIPs:	
	a. Pain in children	Yes
	b. Assessing for cognitive impairment in older people	Yes
	c. Mental health self-harm	Yes
7.	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes
8.	Falls and Fragility Fracture Audit Programme:	
	a. Fracture Liaison Service Database	Yes
	b. National Audit of Inpatient Falls	Yes
	c. National Hip Fracture Database	Yes
9.	Gastro-intestinal Cancer Audit Programme:	
	a. National Bowel Cancer Audit	Yes
	b. National Oesophago-gastric Cancer	Yes
10.	Inflammatory Bowel Disease Audit	
11.	LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)	Yes
12.	Maternal and Newborn Infant Clinical Outcome Review Programme	Yes
13.	Medical and Surgical Clinical Outcome Review Programme	Yes
14.	Mental Health Clinical Outcome Review Programme	No
15.	Muscle Invasive Bladder Cancer Audit	Yes
16.	National Adult Diabetes Audit:	
	a. National Diabetes Core Audit	Yes
	b. National Diabetes Foot care Audit	Yes
	c. National Diabetes Inpatient Safety Audit	Yes
	d. National Pregnancy in Diabetes Audit	Yes
17.	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:	
	a. Adult Asthma Secondary Care	No
	b. Chronic Obstructive Pulmonary Disease Secondary Care	Yes
	c. Paediatric Asthma Secondary Care	Yes
	d. Pulmonary Rehabilitation- Organisational and Clinical Audit	Yes
18.	National Audit of Breast Cancer in Older Patients	Yes
19.	National Audit of Cardiac Rehabilitation	Yes
20.	National Audit of Cardiovascular Disease Prevention (Primary Care)	N/A
21.	National Audit of Care at the End-of-Life	Yes
22.	National Audit of Dementia	Yes
23.	National Audit of Pulmonary Hypertension	No
24.	National Bariatric Surgery Registry	No
25.	National Cardiac Arrest Audit	Yes

Programme count	Programme / Work stream	Participated at MKUH
26.	National Cardiac Audit Programme	
	a. National Congenital Heart Disease Audit	No
	b. Myocardial Ischaemia National Audit Project	Yes
	c. National Adult Cardiac Surgery Audit	No
	d. National Audit of Cardiac Rhythm Management	Yes
	e. National Audit of Percutaneous Coronary Interventions	Yes
	f. National Heart Failure Audit	Yes
27.	National Child Mortality Database	Yes
28.	National Clinical Audit of Psychosis	No
29.	National Early Inflammatory Arthritis Audit	Yes partial
30.	National Emergency Laparotomy Audit	Yes
31.	National Joint Registry	Yes
32.	National Lung Cancer Audit	Yes
33.	National Maternity and Perinatal Audit	Yes
34.	National Neonatal Audit Programme	Yes
35.	National Obesity Audit	No
36.	National Ophthalmology Database Audit	Yes
37.	National Paediatric Diabetes Audit	Yes
38.	National Perinatal Mortality Review Tool	Yes
39.	National Prostate Cancer Audit	Yes
40.	National Vascular Registry[1]	MKUH data is added to Bedford
41.	Neurosurgical National Audit Programme	No
42.	Out-of-Hospital Cardiac Arrest Outcomes	Yes
43.	Paediatric Intensive Care Audit	No
44.	Perioperative Quality Improvement Programme	Yes
45.	Prescribing Observatory for Mental Health:	
	a. Improving the quality of valproate prescribing in adult mental health services	No
	b. The use of melatonin	No
46.	Renal Audits:	
	a. National Acute Kidney Injury Audit	No
	b. UK Renal Registry Chronic Kidney Disease Audit	No
47.	Respiratory Audits:	
	a. Adult Respiratory Support Audit	No
	b. Smoking Cessation Audit- Maternity and Mental Health Services	Yes
48.	Sentinel Stroke National Audit Programme	Yes
49.	Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes
50.	Society for Acute Medicine Benchmarking Audit	Yes
51.	Trauma Audit and Research Network	Yes
52.	UK Cystic Fibrosis Registry	No
53.	UK Parkinson's Audit	Yes

Participation in Clinical Outcome Review Programme 2022/23

Name of Enquiry	Did MKUH participate?
Community Acquired Pneumonia	Yes
Crohn's Disease	Yes
Testicular torsion study	Yes

National clinical audits - Improvements/Actions QIPS to improve quality of care

Specialty	Project Title	Quality Improvements
Acute	Society for Acute Medicine Benchmarking Audit (SAMBA)	No specific recommendations were made. Shortfalls in quality indicators measured were mostly as a result of high patient volumes in ED. A re-audit is expected this year, with the hope there would be some improvement with the commencement of patient review in Same Day Emergency Care (SDEC).
Acute	National audit of Dementia	Further work is required to assess the improvement of diagnosis of delirium and starting discharge planning-in second audit cycle. There is on-going collaborative working with the Frailty team to improve delirium assessments. QIP commenced 2023 - how to prevent unnecessary admission to the hospital among dementia population. Dementia Lead Nurse joining the Trust May 2023.
Cancer Services	National Cancer audits	The Trust are performing well with Multi-Disciplinary Team meetings and Clinical Nurse Specialist input with our patients.

Specialty	Project Title	Quality Improvements
Cardiology	The National Cardiovascular Audit Programme (NCAP)	MKUH is up-to-date with data submission for all of the arms of NCAP. For the heart failure arm of the audit, the audit suggests good practice in several domains (relatively high rates of specialist input, care in a cardiology setting, cardiology follow-up, and higher than average treatment with disease modifying drugs) suggesting that the investment in heart failure services in 2016 has been beneficial and the service we are providing for the patients we are capturing is good. Reporting highlighted the increase in patient numbers. Going back 5 years, the audit numbers have increased.
Colorectal surgery	NBoCA - National Bowel Cancer Audit	Benchmarking is performing well. Recommendations shared January 2023 – no response.
Diabetes	National Diabetes Audit	NDA data to be collected electronically on a quarterly basis. Due to significant challenges on the workload and staffing issues, the diabetes team have not been able to input all cases into the audit.
Emergency Medicine	Royal College of Medicine (RCEM) – Mental Health (Self-Harm)	There are two triage nurses to stream, and risk assess all patients, with some positive impact on mental health patients. Documentation is a key issue. It was identified that the documentation may not have been up to date as the compliance was 2 out of 53 patients seen within 15 minutes. Updating e-care to capture key documentation requirements including risk and actions required following Mental Health team assessment. Improve response time for Mental Health community team input for high and medium risk patient which are always escorted by security. Time between Triage average: further data to be captured.
Emergency Medicine	National audit of seizure management (NASH3)	Discussion with senior ED clinicians regarding the need of Computed Tomography (CT)-Head and Admission in patients presenting with seizures (unnecessary CT-Head and admission may be avoided). Provision of seizure advice leaflet to all patients presenting with seizure including advice regarding driving. All first seizure patients should be referred to First Fit Clinic.

Specialty	Project Title	Quality Improvements
Emergency Medicine	National audit of Pain in Children	The team have adopted a child friendly pain assessment tool to assess the level of pain in children. Other improvements have included development of a Standard Operating Procedure and Patient Group Directives.
Maternity	National Maternity and Perinatal Audit (NMPA)	NMPA Clinical report recommendations: “All women and birthing people should be routinely counselled and offered an episiotomy prior to experiencing a forceps-assisted birth, to reduce the chance of an Obstetric Anal Sphincter Injury (OASI)”. In November 2021 the assisted instrumental birth consent forms were updated. The design was to support consent in the room/theatre, which supports the discussion with the services user and their family about each risk and each intervention including episiotomy. The terminology was changed to make it easier to understand (reducing medical jargon). OASI training was also refreshed in November 2021, and was widely discussed, monitored and audited for all vaginal births. We have seen a reduction of OASI in all vaginal births.
Maternity	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE UK)	MBRRACE recommendation: “Continue to evaluate and implement the national initiatives to reduce stillbirth and neonatal deaths and monitor their impact on reducing preterm birth, particularly the most extreme preterm group.” Saving babies Lives V2 care bundle: The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor. MKUH has a dedicated obstetric and midwifery lead for fetal monitoring. In July 2022 Physiological fetal monitoring was launched. There were 6 months of training for all staff prior to this to ensure all staff had completed a new interpretation, and all staff had the opportunity to attend physiological interpretation training. The fetal monitoring team provides drop-in weekly training to all staff, which includes local and national cases that demonstrate areas for improvement. There is a quarterly fresh eyes audit to ensure staff have the expected reviews of Cardiotocographs (CTGs) and an action plan in place to support persistent 95% compliance. Central monitoring has been implemented in all clinical areas that service users may require a CTG.

Specialty	Project Title	Quality Improvements
Paediatrics	National Paediatric Diabetes Audit	The Paediatric Diabetes team identified the low rate of completion at the time of data submission in mid-2022. This gave the Paediatric diabetes team the opportunity to carefully investigate the reasons for the low completion rate and put measures in place to ensure improvement in these figures. A Work Plan is discussed at quarterly Paediatric Diabetes business meetings. The key action which has already been implemented is to ensure we maximise opportunities to complete health check processes at each patient contact.
Respiratory	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)	The main action plans are: • Create an 'asthma action pack' and keep them in Paediatric Assessment Unit to include – smoking leaflet, asthma information leaflet and inhaler technique and asthma action plans. • We were planning to start peak expiratory flow rate in the specialist asthma clinics in select patients. • Asthma nurse to put prompts on eCARE, the electronic patient record system are to help ward nurses to complete the asthma discharge care bundle. • To identify asthma nurse champions to help support the role • To strengthen the nurse led asthma follow up clinic.

Specialty	Project Title	Quality Improvements
Respiratory	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) COPD clinical audit 2019/20 – pulmonary rehabilitation	• Medical Research Council: chronic obstructive pulmonary disease to always be recorded at assessment this has been cascaded in team training and when training new staff and other questionnaires are not completed with patients due to lack of staff/clinical time.We were planning to start peak expiratory flow rate in the specialist asthma clinics in select patients. • No practice exercise tests performed due to lack of staff/clinical time - unlikely to change unless there is an investment in staff. • Most patients are not given an individualised exercise plan on discharge. All patients to be offered either maintenance programme or Active MK exercise prescription and this to be documented including reasons for not taking up the plan. • There is low uptake and low completion (national problem); no clear idea how to improve this. • Very low numbers of patients from black, Asian and minority ethnic background are referred. This is not representative of the local population. It is not clear why more black, Asian and minority ethnic patients are not referred for pulmonary rehab.
Stroke	Sentinel Stroke National Audit programme (SSNAP)	• Provision of a speech therapist is being explored to enhance the target for a formal swallow assessment within 72 hours of admission. • Improvement is required for the timely escalation of any new stroke diagnoses to the stroke team to enable transfer to the stroke unit within 4 hours of diagnosis. • Review is required of the prioritization of the availability of beds on the stroke unit to enable transfer to the stroke ward as well as meet the target of stroke patients spending 90% of their admission on the stroke ward. • Support is required for data capture for future participation of this audit.
Trauma and Orthopaedics	Fracture Liaison Service Database (FLS-DB) -	Our bone density scans (DEXA) are coming through quicker now, so we are asking the GP to commence treatment before the first follow up, however, the GP are very slow at prescribing this medication. We perform a medication review in the follow up at 4 months and have a help line service.

Local clinical audits - Improvements/Actions QIPS to improve quality of care

Project Title	Quality Improvements and actions required to improve quality of care
Admission criteria and length of stay on ward 14	• Send the survey to Bed managers' team. • A reminder poster in all wards next to the board round • Re-audit in 6 months.
The use of the Multinational Association for Supportive Care in Cancer (MASCC) risk index score and its impact on the length of impatient stay	The use of MASCC risk index score can help reduce unnecessary inpatient stay and optimise the management of cancer patients presenting to the hospital with febrile neutropenia. To complete a second audit cycle collecting data from doctors to ascertain why the MASCC score was not calculated for any patient who presented with febrile neutropenia. The data will be collected in the form of a questionnaire distributed to doctors throughout the trust. Using this data, we can then proceed to a method towards increasing the implementation of this scoring system.
Breast radiotherapy waiting time	With re-audit findings - waiting time to deliver radiotherapy has reduced after patient has been reviewed in MKUH. In-house radiotherapy scheduled to commence in Trust by t December 2023 will remarkably reduce this waiting time further and improve cancer services. Also increasing staff will aid speedy review of patient for consenting and referral will ensure the 30 days post-operative interval as recommended by NHS. We are at par with our peers nationally in the Quality Performance Indicators (QPIs) dealing with the very high risk (VHR) population. Results were comparable with national findings.
Maintenance of peripheral venous cannula (PVC) using visual phlebitis score (VPS)	To make nursing staff who are monitoring VPS score aware about action plans that need to be followed once PVC started showing sign of inflammation. Doctors doing rounds should also pay attention to PVC lines during bedside examinations and ward rounds. Highlight the role of appropriate use of VPS in preventing Heath care associated blood stream infection.
Accessing patients admitted with chest infection by using CURB 65 score second cycle	Encourage doctors to use CURB65 (British Thoracic Society scoring) while admitting patient with pneumonia. Used the calculating score to determine the suitable choice of antibiotics. Poster will be placed in the Acute Medicine Unit and Ambulatory Emergency Care Unit and to other wards. To add short cut documentation for the CURB65 on the e-care to encourage the ue using the score tool. Second cycle showed improvements in the documentation comparing the first cycle. One figure used instead of using the whole figures of whole score.
Discharge summary QI project	This QIP is to improve the quality of discharge summaries shared with patients and general practitioners. A range of improvements have been undertaken including a revised discharge summary layout in line with the Situation, Background, Assessment, Recommendation (SBAR) categories which is audited for quality of completion each month. Staff competencies are followed up by educational supervisors.
Medicines Management QI project	This QIP was initiated to reduce the number of incidents related to medication errors from initial prescribing to receipt of summary by general practitioner.
Preoperative Anemia QI Project	QIP commenced to reduce delays to patient surgery.

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 of providing patients with the latest medical treatments and devices and offering 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, benefiting 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 2022/23 were recruited to participate in National Institute of Health Research (NIHR) studies approved by a research ethics committee. In 2022/23 over 7,823 were recruited to 93 studies in the Trust, from the 4,576 patients were recruited to 106 studies in 2021/22. The Research and Development (R&D) Department received funding of over £870,000 for 2022/23 to deliver the NIHR portfolio research.

This year the team has continued to grow to support the increasing research activity across the Trust. The budget award for 2023/24 is still to be finalised. However, it is expected to be over £900,000, to support the delivery of first-class research our patients and local community.

The Department has supported and delivered training of new research staff at MKUH and through network supported training programmes eg virtual and online 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 (2022/23) over 87 publications have resulted from our involvement in research, demonstrating our commitment to improve patient outcomes and experience across the NHS.

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 '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.

2.6 Goals agreed with Commissioners

A proportion of Milton Keynes University Hospital NHS Foundation Trust income in 2023/24 was conditional upon achieving quality improvement and innovation goals agreed between Milton Keynes University Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

2022/23 CQUINs for Milton Keynes University Hospital NHS Foundation Trust

Indicator	Indicator Name	High level detail	Expected delivery 2022/23
CCG1	Flu vaccinations for frontline healthcare workers	Achieving 70-90% uptake of flu vaccinations by frontline staff with patient contact.	The Trust achieved a total frontline flu vaccination uptake of 73%.
CCG3	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.	This CQUIN has been achieved in full.
CCG4	Compliance with timed diagnostic pathways for cancer services	Achieving 65% of referrals for suspected prostate, colorectal, lung and esophagogastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	This CQUIN has not been achieved.
CCG8	Supporting patients to drink, eat and mobilise after surgery	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	This CQUIN has been achieved in full.
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	This CQUIN has been achieved in full.

2.7 Care Quality Commission (CQC) Registration and Compliance

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

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

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

The Trust participated in a limited inspection of Maternity in March 2023, as part of a national programme of maternity inspections, aiming to inspect all maternity services in the country before the end of April 2023.

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 & 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::

- The Data Quality 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.
- 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).
- 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 2022/23 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, and outpatients for ethnicity and outpatients 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[1]	Outpatients[1]	ED[2]
Completeness NHS number	99.5% (99.6%)	99.8% (99.8%)	98.9% (98.8%)
Completeness ethnicity	98.6% (94.8%)	95.5% (93.0%)	96.4% (95.4%)

1 Admitted / Outpatient figures taken from the national SUS+ data quality dashboard – national average in brackets was the latest set of information available at the time of writing this report (M11 28 February 2023).

2 ED figures taken from the Emergency Care Data Set data quality dashboard - national average in brackets was the latest set of information available at the time of writing this report (M12 11 April 2023).

2.9 Qualitative Information on Deaths (While Maintaining Patient Anonymity)

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

Qualitative mortality review is undertaken by the Medical Examiners, the Coronial System, Mortality and Morbidity Meetings, Structured Judgement Reviews, and a variety of multi-agency review teams looking at deaths that occur in specific circumstances: the peri-natal period, in patients with learning difficulties and in pregnant women.

The Trust implemented the Medical Examiner system in May 2019 and has a team of ten medical examiners who work on a sessional / part-time basis. This includes senior general practitioners and hospital consultants from a range of specialties to provide a breadth of clinical experience and expertise.

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

Deaths with concerns raised regarding care delivery undergo a formal Structured Judgement Review (SJR). SJRs are carried out by trained reviewers who look at the medical records in a critical manner and comment on all phases of care. The output of the SJR is presented at departmental Mortality and Morbidity Meetings. Lessons learned are disseminated within the specialty through local Clinical Governance Meetings. The Trust has commissioned an electronic interface that will provide a single point-of-reference for all completed SJRs across the Trust, with the facility for real-time reporting and review, providing additional oversight and the opportunity for organisation-wide learning.

The Medical Examiners' office at the Trust extended the Medical Examiner system to include scrutiny of deaths in hospice settings from December 2022, and a pilot trial with 6 Milton Keynes general practices is currently underway to review deaths in community settings. This is being extended to review deaths from all GP practices in Milton Keynes later this year through a process of incremental recruitment of further practices.

The Medical Examiner service has received positive feedback from bereaved families and has encouraged positive communication with the Coroner's Office.

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 learning into practice. The Trust reported 4 deaths to the LeDeR programme in 2022. The Trust has a full-time learning disability coordinator who supports the pathway for the SJR process with LeDeR review. This takes place as part of the Bedfordshire, Luton and Milton Keynes (BLMK) review group and provides external independent review. Recommendations from the review are put into practice. Actions include improving communications with families, learning disability awareness to ensure adjustments to care are made, assessments and formal processes such as the Deprivation of Liberty Safeguards are followed. We have a specialist Learning Disability Nurse to advise and support staff, carers, and patients.

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

Table 1. Review and Investigation of Deaths 2022

	Q4 Jan-Mar 2022	Q1 Apr-Jun 2022	Q2 Jul-Sep 2022	Q3 Oct-Dec 2022
Number of deaths	278	274	269	349
Number of deaths reviewed by Medical Examiner	100%	100%	100%	100%
Number of Structured Judgement Reviews (SJRs) Requested by Medical Examiner	16	29	28	25
% Deaths in which SJR requested	5.7%	10.5%	10.4%	7.2%
Cases taken for investigation by the coroner following referral (% of total deaths)	10.4%	10.6%	14.4%	15.5%
Cases in which Medical Certificate of Cause of Death (MCCD) (Form A) completed after discussion with Coroner (% of total deaths)	12.5%	11.9%	8.9%	12.9%
% (Number) of Urgent Release completed paperwork within 24hours †	75% (3/4)	100% (3/3)	83% (5/6)	100% (2/2)
MCCD completion within 3 days	93.5%	92.1%	97%	91.4%
Number of Relatives directed to Patient Advice and Liaison Service (PALS)	4	11	7	13
Number of MCCDs rejected after Medical Examiner scrutiny	4	8	4	18
Deaths of people with Mental Health or Learning Disability diagnoses	0	0	4	0

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

In relation to its national peers, unadjusted mortality and HSMR are consistently in the 'mid-range' and SHMI remains 'as expected'.

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

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

Current alerts include the diagnostic categories of 'pneumonia (excluding Covid pneumonitis and TB)', urinary tract infection and 'other perinatal conditions' which includes still births, late terminations of pregnancy and neonatal deaths. Review of these alerts has led to quality improvement programmes in clinical documentation and engagement with local and national quality improvement programmes. Importantly, no significant concerns have been identified in relation to the clinical care pathways for these conditions.

Figures 1-3 show the position of MKUH (highlighted blue) compared to national peers for unadjusted mortality, HSMR and SHMI respectively.

Figure 1. Unadjusted Mortality Rate

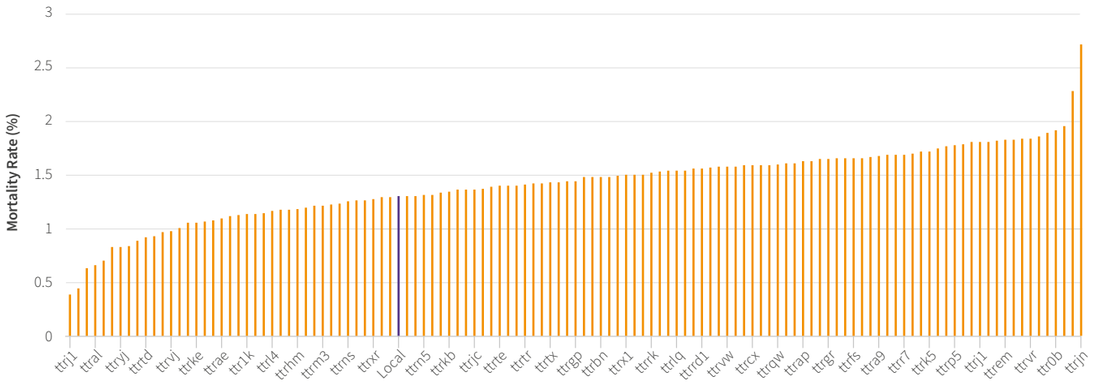


Figure 2. HSMR

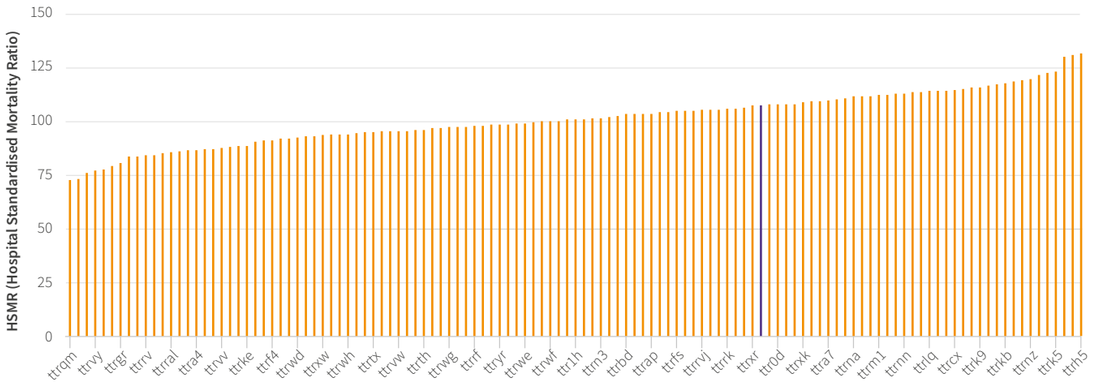
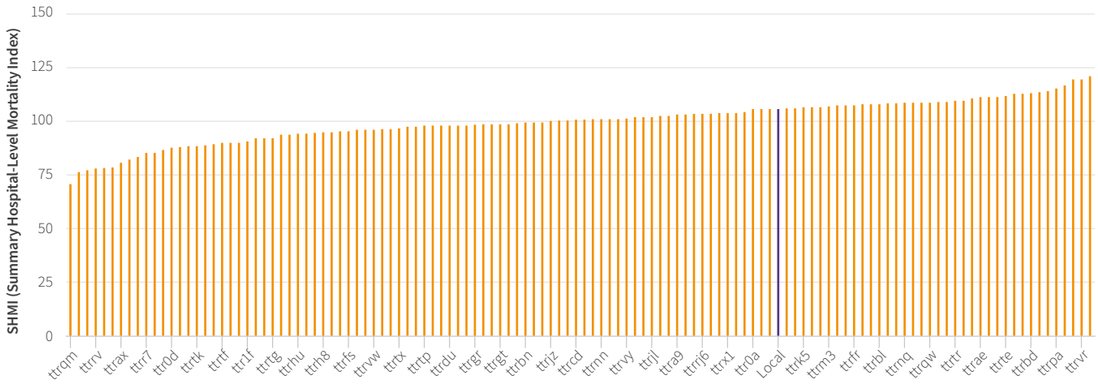


Figure 3. SHMI



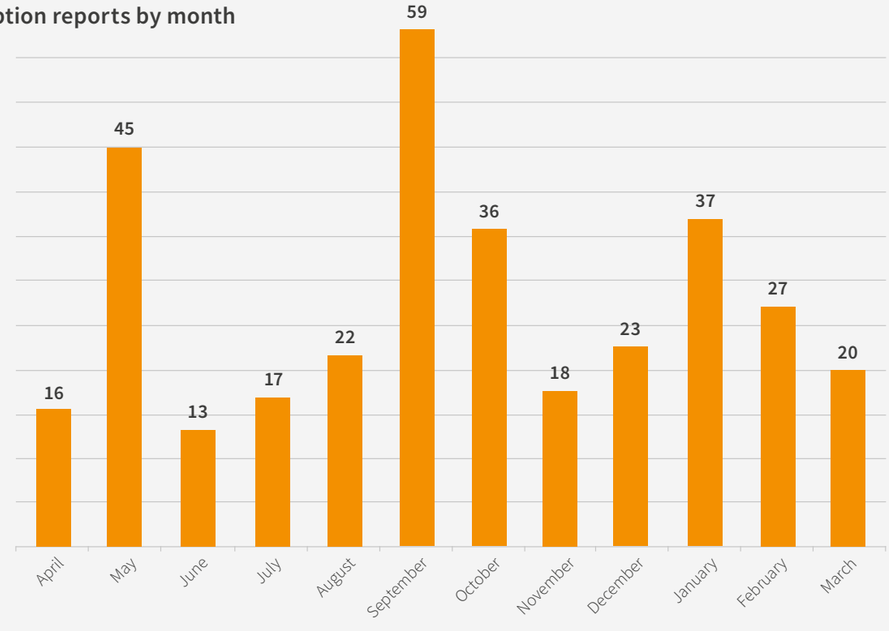
2.10 Report by the Guardian of Safe Working Hours

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.

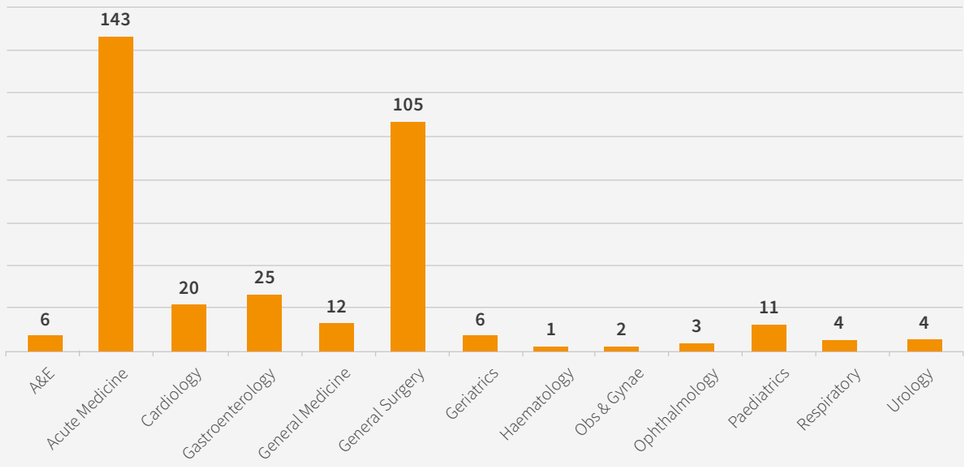
Exception reporting is the process where a trainee doctor can raise issues with their educational supervisor in relation to one or more of: their hours of work; the level of support offered to them by senior colleagues; or training opportunities which vary significantly from those described in their 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 2022 – 01 March 2023 the following exceptions have been reported:

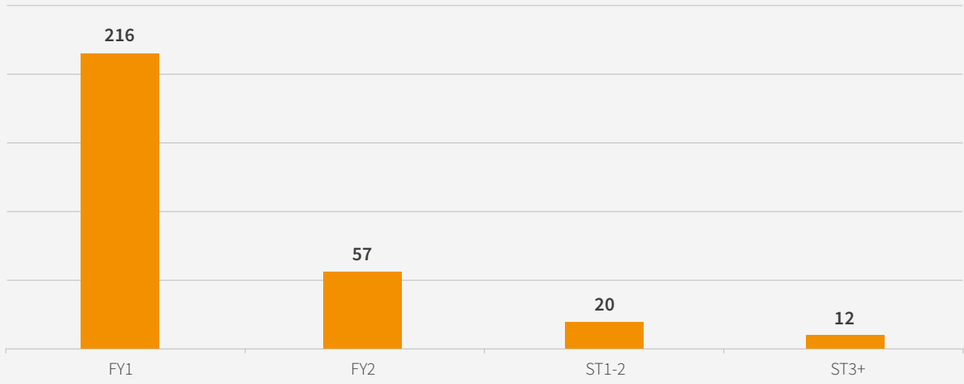
Exception reports by month



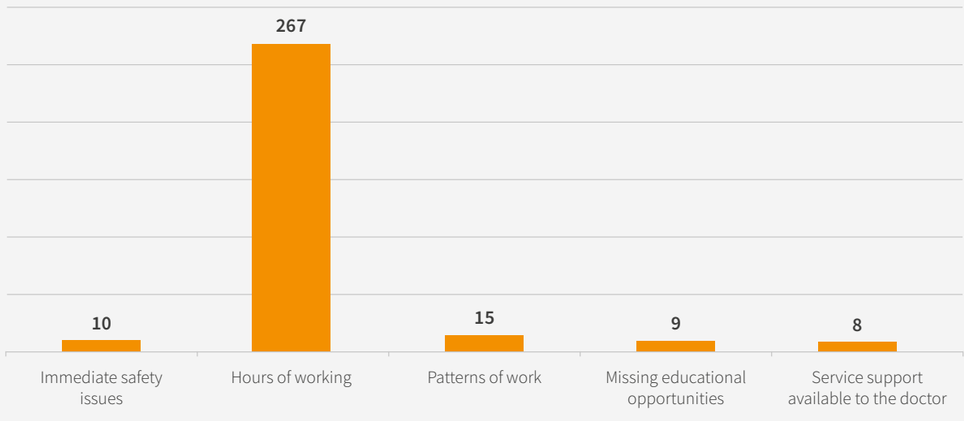
Exception reports by department



Exception reports by grade



Reasons for exception reporting



In summary, there were 299 exception report from April 2022 to March 2023, which indicates adequate use of exception reporting system by junior doctors (compared to 164 in previous year). Peak months of exception reporting were May, September and January which does not follow any regular trend. In previous year, maximum numbers of exception reporting happened during winter months.

The exception reports were from acute medicine (47.8%) and general surgery (35%) along with other acute medical specialties Gastroenterology (8%) and cardiology (6%). These follow the similar trend from previous years.

89% of reports were due to working additional hours ie staying late during ward duties on weekdays and on calls and most quoted reasons by trainee doctors were pressure of acute patients and staffing shortages. These patterns are similar as previous years.

There were 10 exception reports with immediate safety concerns all of them were due to low staffing levels during acute on calls. 4 were form acute medicine, 5 from general surgery and 1 from haematology. All the exception reports were appropriately discussed in relevant departments, trainees and educational supervisors and acknowledged for regular review of on-call staffing levels and maximum efforts to be given for short notice sickness cover for on-call shifts specially for night and weekend on-call cover. There were no actual patient safety concerns. All the exception reports with safety concerns were also from foundation year doctors. Communications were made to the relevant educational and clinical supervisors for adequate support to junior doctors in particular during on-calls.

As usual trend over years, the majority of exception reports were from foundation year one doctors (72%) which reflects junior trainee doctors needing more support including adequate ward staffing, senior support and reflects junior trainee doctors are more efficient in escalating issues and are aware of the exception reporting system.

55.5% exception reports (166 out of 299) were resolved with payment, 25.7% (77 out of 299) were resolved with time in lieu. There were staffing level changes as explained before in cardiology department as outcome of the exception reports along with medicine rota changes with some increase in trust grade doctors staffing levels. There were 32 unresolved exception reports from surgical department which have been escalated to the surgical division and await actions at the time of writing this report.

2.11 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 out over concerns ranging from patient safety, quality of care, bullying, to incivility, we encourage staff members to use the Freedom to Speak Guardian. The team includes a Freedom to Speak Guardian, four other Guardians and five Freedom to Speak Up Champions who act as signposts to the Guardians.

There is clear support from the Chief Executive Officer and Trust Board lead for Freedom to Speak Up. The Trust has a comprehensive and accessible Speaking Up Policy which supports how colleagues can raise concerns with the FTSU Guardians and Champions and ensures that confidentiality 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 because of raising a concern. In addition to the policy, there is Trust-wide signage outlining the contact details of the FTSU Guardians and Champions (telephone number, email address, and QR code link).

A postcard has also been developed that is handed at staff induction for example. 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 2022 to March 2023 there has been 47 cases recorded and reported to the National Guardians Office, from 21 cases reported in the previous 12 months. The Lead Guardian is using the East of England regional Guardians group and other resources to seek ideas to improve the uptake of the Guardian service. Staff who have spoken up in the past have not reported any detriment to them for doing so. During the same period, there were 969 contacts made to the Trust's informal and confidential P2P (Peer to Peer) listening service, from the 1,019 contacts made in the previous 12 months.

The current Lead Guardian has had opportunities in 2022-23 to speak to various groups, such as managers on the Managers Way program, and newly recruited Healthcare Support workers. Further opportunities to raise the FTSU profile are being developed, including sessions with nursing and medical students. This is helped by the Trust offering Guardians allocated time for FTSU activities, and from April 2022 allowing the Lead Guardian to be paid of 7.5 hours per week (having reduced hours in their clinical role) and from October 2022 up to 15 hours per week paid in the Guardian role. From January 2023 this has become a part-time role for the Lead Guardian.

MKUH has introduced Freedom to Speak Up into mandatory training for staff by using the 3 videos: Speak Up, Listen Up, and Follow Up.

There is a dedicated email address **freedomtospeakup@mkuh.nhs.uk** for staff to contact the Guardians, and there is a mobile telephone line 07779 986470 as another way of contacting the Guardians, particularly for staff who do not normally use email. The QR code system has been used on occasion though a technical difficulty led to a delay in responding to concerns raised at the end of 2022. These were addressed as soon as identified. On follow-up, some cases were reported not to need further action and where necessary witnesses were invited to Speak Up and have their concerns addressed.

2.12 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**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
(a) The value and banding of the Summary Hospital-level Mortality Indicator ('SHMI') for the trust	**MKUHFT**	0.99 (Band 2)	1.05 (Band 2)	1.09 (Band 2)	1.16 (Band 1)	1.07 (Band 2)	1.07 (Band 2)
	National	1.0	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**	47%	48%	47%	54%	53%	51%
	National	32%	34%	36%	36%	39%	40%
	Other Trusts Low/High	12% / 60%	14% / 60%	12% / 59%	8% / 59%	11% / 64%	12% / 65%

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 Venous thromboembolism (VTE)

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm							
23. Domain of Quality	**Level**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
Patients admitted to hospital who were risk assessed for venous thrombo-embolism (Q3 results for each year)	**MKUHFT**	76.9%	96.8%	98.0%	Not Available	Not Available	Not Available
	National	95.4%	95.7%	95.3%			
	Other Trusts Low/High	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 2021/22 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, Venous thromboembolism (VTE) Assessments were suspended in 2020/21, and remained suspended in 2021/22 and 2022/23.

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

24. Domain of Quality	Level	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
C.difficile infection rate per 100,000 bed days (Hospital-onset)	**MKUHFT**	7.1	8.6	5.1	6.5	10.5	Not Available
	National	13.6	12.2	13.6	15.4	16.2	
	Other Trusts Low/High	0 / 90.4	0 / 79.8	1 / 51.0	0 / 80.6	0 / 53.6	

NB: The national data for 2022/23 is not yet available from NHS Digital.

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

There were 6,983 Patient Safety incidents reported last financial year. This equates to a reporting rate of 40.06 incidents per 1,000 bed days. Of these 81 (1.15%) were categorised as Major/Catastrophic.

The Trust reports patient safety incidents directly to NHS England via the Learning from Patient Safety Events (LFPSE) system. NHS England uses the data to monitor incident trends NHS-wide and they produce a bi-annual report comparing the Trust to other acute organisations. The reporting rate of all incidents has decreased following a move to a new incident reporting system. A drop in incident reporting when implementing a new system is not unexpected and there has been an ongoing increase in reporting since the since went live. Actions have been put in place to increase awareness of the importance of reporting incidents and to encourage the report of incidents including ongoing between staff, NHS England and the system provider to make reporting quicker and easier for staff. The Trust continues to be one of the lowest reporting organisations.

Comparative data between MKUH and other Trusts is currently not available, as MKUH were the first Trust to move across to NHS England's LFPSE system. There are still few Trusts that have switched from the National Reporting & Learning System (NRLS) to the LFPSE system to date. NHS England (NHSE) have mandated that all Trusts move across to the LFPSE system by 30 September 2023. Therefore we expect that improved benchmarking will be made available in the future.

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.

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

Domain 4: Ensuring that people have a positive experience of care							
20. Domain of Quality	**Level**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
Responsiveness to inpatients' personal needs	**MKUHFT**	63.1%	64.5%	62.6%	71.6%	Not Available	Not Available
	National	68.6%	67.2%	67.1%	74.5%		
	Other Trusts Low/High	60.5% / 85.0%	58.9% / 85.0%	59.5% / 84.2%	67.3% / 85.4%		

Domain 4: Ensuring that people have a positive experience of care							
20. Domain of Quality	**Level**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
Staff who would recommend the trust to their family or friends	**MKUHFT**	66%	68%	70%	76%	Not Available	Not Available
	National	70%	70%	71%	74%		
	Other Trusts Low/High	47% / 89%	41% / 90%	41% / 88%	50% / 92%		
Patients who would recommend the trust to their family or friends (Inpatient FFT - February in each year available)	**MKUHFT**	97%	96%	96%	94%	94%	93%
	National	96%	96%	96%	100%	99%	94%
	Other Trusts Low/High	82% / 100%	76% / 100%	80% / 100%	41% / 100%	77% / 100%	66% / 100%

3 Other Information

3.1 Patient Experience

3.1.1 Complaint Response Times

The total number of complaints received for 2022/23 totalled 1144. When compared to 2021/22 this amounts to an increase of 9.8% (2021/22 n = 1042).

All complaints are triaged by severity upon receipt. The number of complaints received by severity for 2022/23 is detailed below:

Red - Severe harm	0
Amber - Moderate Harm	182
Yellow - Low Harm	945
Green - No Harm	17

In percentage terms the number of no and low-harm complaints amounts to 84.1% (83.6 % 2021/22) of total complaints received.

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

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

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

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

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

Divisional compliance with these timescales is monitored and reported through the Trust's scorecard which is reported to the Board monthly. The target for responding to complaints in the timescales agreed with the complainant is set at 90%. The Trust has achieved an average monthly performance of 91.5%.

3.2 Patient Safety

3.2.1 Duty of Candour

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

Duty of candour 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 2022/23 Service Quality Performance Reports report full compliance based on the Trust's incident reporting system (Radar). Duty of candour dashboard 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 4 PFDs from HM Coroner in the year 2022 – 2023 which related to:

May 2022

Concern expressed in relation to:

The Intensive Care Unit (ICU) alarms that are operating on the monitors had been disengaged. This resulted in the staff not being alerted when the patient's saturations fell below an acceptable level and he went into cardiac arrest. The understanding was that if a patient was being monitored at all then it was essential that the alarms remain operational.

The Trust's response noted that there is no national guidance regarding frequency of observations in ICU and patients vary from those who are acutely unwell to those who are well and waiting for a ward bed and on occasions direct discharge home. Observations (frequency and type) are decided by ongoing dynamic risk assessments from the nurse looking after the patient with input from the medical team as required.

Alarm fatigue is a recognised detrimental consequence of intensive, continuous monitoring. As part of the wider learning from this incident, the importance of proportionate and appropriate use of alarms and alarm limits will be emphasised to all critical care staff.

November 2022

Concern raised in relation to:

- The discharge of a patient from hospital following surgery, having refused to wait over the weekend for a care package to be put in place with no follow-up arranged to either assist him with his care or to ensure that he was coping.
- That when the GP practice made a subsequent referral for a visit and assessment by the district nurse it was rejected on the basis that the appropriate referral was to "home first". The GP forwarded the referral, but nothing was actioned.
- There does not appear to be any system to ensure that a patient discharged home possibly needing support and care are automatically followed up.

The Trust responded advising that we had not identified anything that we would seek to do differently in similar circumstances. An elderly gentleman received prompt surgical treatment and his discharge needs were subsequently explored with him and his family by appropriate members of staff. The professional opinion was that no formal support was required, and signposting information was provided such that he would know where to go for support should his situation change. The gentleman was judged to have mental capacity throughout his admission and did not 'refuse to wait over the weekend for a care package'. He was not judged to require a care package, nor did he or his partner seek one.

January 2023

HM Coroner raised concerns in summary that:

The surgical team in charge of the patient had no effective knowledge of the sepsis protocol. They failed to monitor him effectively or consistently despite clear signs of deterioration. They failed to provide adequate support and supervision to the FY1 and they failed to institute an effective senior review at any point on 9 April 2021 until critical deterioration, by which time the patient's chances of death due to his rapid deterioration and multi-organ failure were 80 to 100%.

The Trust's response detailed:

- A review of the surgical staffing models and the introduction of a standard operating procedure (SOP) for when juniors should escalate outside the specialty team for support.
- Adjustments of nursing establishments to provide a designated senior nurse on shift.
- To operate and development system that enable a daily consultant patient review.
- To develop ways in to display patient acuity to ward teams (care view dashboards).
- Revision of the policies relating to sepsis and the deteriorating patient to align the National Early Warning Scores (NEWS) that trigger an escalation (with more emphasis on the registered nurse responsibility to undertake observations in the deteriorating patient and enhanced guidance on how to take observations).
- Revision of the sepsis policy algorithm to include ongoing investigation, escalation and care.
- The enactment of training and education interventions to prevent further incidents of missed patients.

March 2023 (formal report pending)

Concern raised in relation to evidence relating to the root cause analysis (RCA) investigation which the Coroner described as "extraordinary suggesting an attitude in the Emergency Department which was lassiez-faire at the very least for this and other patients with regards to fluid management".

3.2.3 Serious Incidents (SIs) & Never Events

The Trust reported 1 Never Event in the year 2022-23 for Endoscopy, where a patient underwent an invasive procedure (gastroscopy, OGD) that was not intended for her, including cannulation, sedation and 4 biopsies.

The Trust reported 88 SIs in the year which can be broken down as follows:

SI Category	Number of incidents
Pressure Ulcer (deep tissue injuries)	27
Delayed Diagnosis	8
Sub-optimal care of the deteriorating patient	1
Drug Incident	16
Surgical error	2
Slips, Trips, Falls	4
Maternity Service - Unexpected admission to NICU	3
Death of a Patient Under the Mental Health Act	1
Maternity Service - Intrauterine Death	3
Equipment/Device Failure	2
Safeguarding Vulnerable Adult	1
Child Death	1
Treatment delay	2
C. diff/healthcare-acquired infection	3
Accident	1
Violence & Abuse/Disruptive Behaviour	1
Venous thromboembolism (VTE)	5
Unexpected death of an adult (including 1 maternal death)	5
Complications of Surgery	1
Maternal incident	1
Total	**120**

The Trust's Serious Incident Review Group (SIRG) consisting of staff from across the Multi-Disciplinary Team, reviews all incidents reported on Radar 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 2022/23 were:

- New pressure ulcers (deep tissue injuries) – Care, Review and Learning Group established by corporate nursing team to ensure accuracy of pressure damage validation and Harm Improvement Group leading on cross-themed action plan. Agreement with the ICB from October 2022 only new pressure ulcers with significant harm were reported as serious incidents reducing the volume of root cause analysis investigations and in recognition that time could be better spent working on actions to improve the patient care/safety.
- Medication incidents. Medicines reconciliation improvement project established. This is a multi-professional collaborative project with members from Quality Improvement (QI), patient safety, pharmacy and medical staff looking at the system factors associated with the safe reconciliation and prescribing of patients' regular medications. Areas of focus include multi-professional/cross-team working, technological aids, pharmacy capacity and support, learning and education.
- Medication incidents relating to insulins and management of diabetic ketoacidosis (DKA) and staffs' familiarity on protocols and insulin type variances and effects on blood sugars. Given this trend in incidents relating to diabetes/ insulins, a diabetic safety group has been set up.
- Diagnostic delays due to administrative and IT processes and systems leading to delayed or missed appointments.
- Increase in violence and abuse between staff and patients/third parties to staff (verbal and physical).
- Record keeping and eCare documentation etiquette.
- Patients with mental health needs with an increase in self-harm incidents.
- Reduction in patient falls resulting in significant harm.

The national Patient Safety Incident Response Framework (PSIRF) will replace the current Serious Incident Framework (2015) and represents a significant shift in the way the NHS responds to and learns from patient safety incidents and other safety intelligence. All NHS organisations are mandated to transition over to PSIRF by Autumn 2023. This approach is more collaborative and enables staff and patients involved to share their perspective of events and the impact this had. The Trust is networking with national and regional PSIRF groups (NHSE, Patient safety specialist national group, Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS) & BLMK Local Maternity & Neonatal System, Buckinghamshire, Oxfordshire and Berkshire West, the BOB ICS) as part of the implementation.

Learning is shared in local and Trust-wide newsletters and governance reports for clinical improvement meetings (CIGS), with escalation reports to corporate governance committees. SIRG also has an agenda item for 'spotlight on safety' flagging key learning points from the meeting to be included in the CEO weekly newsletter sent to all staff. The Trust also has the Greatix system for sharing learning and congratulating individual staff.

3.2.4 Midwife-to-Birth Ratio

The midwife-to-birth ratio is calculated following the completion of a recognised midwifery staffing workforce assessment. Currently this is predominantly provided to maternity services by Birth Rate Plus who have a framework specifically aligned with midwifery workforce planning on which to base the organisation of staffing.

Birth Rate Plus calculate the midwife-to-birth ratio taking into consideration the individual acuity within specific maternity services and a full workforce review should ideally take place every 3 years to reassess the staffing requirements based on updated acuity levels.

A birth rate plus assessment took place in 2018 which recommended a midwife-to-birth ratio of 1:28, a further Birth Rate Plus assessment took place and was published in May 2022 which recommended a midwife-to-birth ratio of 1:24.

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

Month	Midwife to birth ratio
April 2021	1:33
May 2021	1:31
June 2021	1:34
July 2021	1:34
August 2021	1:34
September 2021	1:33
October 2021	1:35
November 2021	1:33
December 2021	1:35
January 2022	1:31
February 2022	1:33
March 2022	1:33

The average ratio for 2022/23 was 1:32.

3.2.5 Statutory and Mandatory Training

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

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

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

	Q1	Q2	Q3	Q4
2017/2018	91%	89%	90%	89%
2018/2019	90%	89%	90%	93%
2019/2020	93%	92%	94%	94%
2020/2021	94%	95%	95%	97%
2021/2022	96%	96%	96%	94%
2022/2023	95%	92%	94%	94%

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

3.3 Clinical Effectiveness

3.3.1 Cancer Waits

There is a significantly increased number of people being diagnosed with cancer and living with the condition. Current figures show that one in two people will be diagnosed with cancer in their lifetime, and it is expected that by 2030 3.4 million people will be living with cancer and beyond cancer.

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

During the pandemic, Cancer Services were asked to prioritise elements of the NHS Long Term Plan that could help with recovery, such as the roll-out of the faster diagnosis of non-specific symptoms across the country, with a further 20 places due to join the programme in 2022. These are important building blocks towards meeting the ultimate ambition of 75% diagnosis at stage 1 and 2 by 2028.

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

Milton Keynes University Hospital has developed services and continues to develop services in line with the NHS 10-year Cancer Plan and has provided a lot of focus on recovery and restore programmes across specialities. Multidisciplinary teams have access to cancer performance targets and a live patient tracking tool to enable the management of patients' pathways and the early identification of delays and trends of issues. There are weekly restore and recovery meetings managed with the Head of Cancer Services with all operational speciality leads and speciality cancer leads to discuss patient level detail, harm reviews and capacity and demand management.

There is a further weekly overview of the cancer position and risks at the Executive Patient Tracking List meeting, alongside this there are escalation alerts sent to the divisional and executive leads for any pathway that is raising concerns and resulting in patient delays. Cancer Services' Operational Lead meets with the BLMK ICS Governance Lead to review cancer breaches monthly and presents root causes analysis and risk assessments for those raising concerns as required and identifies actions in place. Both MKUH and BLMK ICS report the cancer positions back through their Board meetings.

The Trust actively works with the Cancer Alliance and both East of England and the Thames Valley Cancer Strategic Clinical Network on the new cancer standards, striving to provide a faster diagnostic pathway of 28 days to enable patients receiving treatment within the 62-day standard. 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 with their colorectal Straight to Test (STT) pathway being invited to speak at the network conference due to their good performance against the national position. There is an active cancer clinical improvement group and there is a current review to combine the cancer leads improvement group with the primary care cancer group to enhance collaborative working, share lessons learnt and develop new pathways.

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. Over the last 3 years we have filled the capacity within the centre increasing the chemotherapy unit from 24 spaces to 32. Ward

25 utilises the 4-bed acute assessment unit on a regular basis to increase inpatient provision to 24 beds. The majority of clinic rooms are full daily with only minimal capacity for overflow clinics. The wellbeing area has re-opened to group therapy and education sessions providing a valuable resource to both patients and staff.

2023 saw the commencement of the radiotherapy build alongside the Cancer Centre. This is being built in conjunction with Oxford University Hospital (OUH) to support the Milton Keynes vision of 'treatment closer to home'. This had been a long-term action from patient experience surveys to ensure that treatment was close to where they lived with all services under one roof. 2023 also saw the cancer patient experience survey from 2022 returned seeing MKUH in the top quartile of the country for good patient experience with an overall score of 8.9 out of 10.

The Cancer Services team have worked to maintain recovery to the cancer pathways post the COVID-19 outbreak 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. MKUH has recently seen a peak in 2-week referral demand at 56% increase above pre-covid level 19/20. This has seen a sharp increase in demand for diagnostic services following the development to STT pathways. This remains challenging and requires daily tracking to ensure patients are booked in priority order and escalation to capacity concerns. There was recent investment via the East of England Cancer Alliance for cancer navigator posts in Imaging and Pathology to support this patient tracking which have helped to support this valuable work. Cancer performance remains challenged due to the volume of cancer referrals received over the year with an increase of 16,528 referrals against the March 2020 pre-pandemic position.

All patients on the cancer tracking pathway are clinically reviewed and harm reviews undertaken for patients over 62 days. Patients are managed in priority order alongside the performance measures to ensure best clinical practice is maintained.

2-week wait cancer performance

Tumour Site	Q1	Q2	Q3	Q4	YTD
Brain/CNS	98.1%	86.1%	90.6%	81.0%	89.7%
Breast	91.6%	94.1%	94.7%	95.0%	93.8%
Colorectal	55.2%	32.8%	50.9%	44.3%	45.2%
Gynaecology	72.5%	55.6%	59.5%	47.5%	58.6%
Haematology	83.9%	75.7%	61.8%	82.5%	76.1%
Head and Neck	85.0%	90.2%	86.6%	86.1%	87.0%
Lung	48.4%	29.8%	84.3%	74.7%	60.2%
Skin	94.4%	94.2%	93.3%	95.7%	94.4%
Upper GI	79.3%	73.3%	87.6%	71.4%	77.4%
Urology	83.2%	87.5%	88.4%	81.8%	85.4%
Other	72.7%	50.0%	75.0%	50.0%	62.7%
Paediatrics	82.1%	89.2%	85.2%	82.6%	85.2%
Grand Total	**80.7%**	**73.2%**	**79.8%**	**75.3%**	**77.1%**

28-day cancer performance

Tumour Site	Q1	Q2	Q3	Q4	YTD
Brain	88.5%	90.6%	89.1%	82.9%	87.8%
Breast	93.9%	94.6%	95.3%	97.4%	95.3%
Breast Symptomatic	96.1%	97.6%	96.7%	96.4%	96.6%
Colorectal	70.4%	72.6%	69.3%	71.0%	70.8%
CUP		33.3%		50.0%	40.0%
Gynaecology	51.4%	53.3%	56.4%	51.9%	53.2%
Haematology	55.6%	40.6%	30.3%	32.0%	39.3%
Head and Neck	64.2%	59.4%	65.8%	64.9%	63.6%
Lung	50.5%	26.2%	67.9%	70.3%	53.5%
Paediatric	86.1%	90.5%	90.2%	93.5%	90.0%
Skin	83.2%	94.1%	98.2%	96.1%	92.7%
Upper GI	71.1%	56.8%	73.9%	70.3%	67.8%
Prostate	17.2%	20.0%	17.4%	25.0%	18.9%
Urology	49.6%	38.8%	53.4%	53.6%	49.2%
Other	33.3%				42.0%
Grand Total	75.2%	74.3%	78.0%	78.7%	76.6%

31-day cancer performance

Tumour Site	Q1	Q2	Q3	Q4	YTD
Brain		100.0%	100.0%		100.0%
Breast	92.1%	94.3%	95.8%	79.5%	90.3%
Colorectal	97.9%	92.5%	89.5%	90.5%	92.5%
Gynaecology	100.0%	81.8%	64.3%	81.3%	77.8%
Haematology	100.0%	97.8%	100.0%	100.0%	99.3%
Head and Neck	91.7%	85.7%	88.9%	100.0%	91.1%
Lung	100.0%	100.0%	100.0%	89.7%	96.9%
Skin	100.0%	98.8%	100.0%	94.3%	98.6%
Upper GI	100.0%	96.9%	100.0%	100.0%	99.1%
Urology	93.8%	91.6%	93.6%	95.5%	93.6%
CUP				100.0%	100.0%
Paediatric					
Other					
Grand Total	**96.5%**	**94.8%**	**94.5%**	**91.5%**	**94.3%**

62-day cancer performance

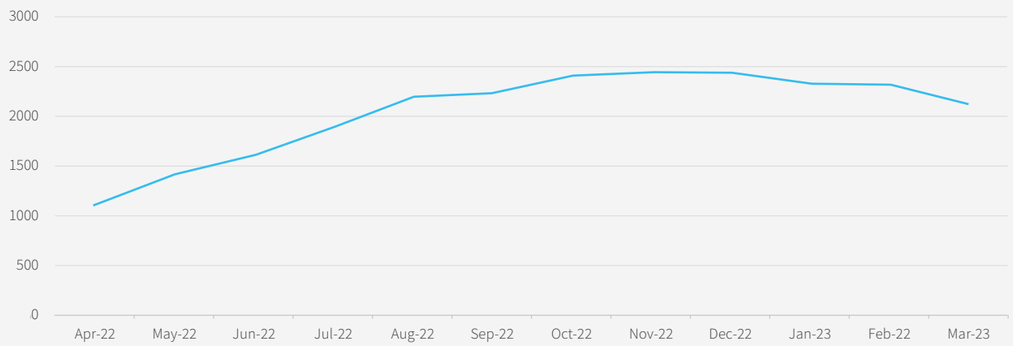
Tumour Site	Q1	Q2	Q3	Q4	YTD
Brain					
Breast	68.1%	66.7%	75.3%	58.9%	67.7%
Colorectal	61.2%	45.6%	47.6%	38.0%	47.9%
Gynaecology	0.0%	34.8%	26.1%	20.0%	24.7%
Haematology	100.0%	71.4%	33.3%	75.0%	71.0%
Head and Neck	31.3%	14.3%	41.7%	10.5%	27.2%
Lung	80.0%	55.6%	68.8%	47.6%	60.8%
Other					
Skin	95.6%	98.0%	89.9%	96.8%	95.0%
Upper GI	42.9%	69.0%	57.1%	21.1%	50.0%
Urology	38.9%	64.9%	62.3%	40.8%	51.4%
Grand Total	**62.5%**	**66.1%**	**63.9%**	**50.7%**	**61.0%**
Including Rarer Cancers	**63.0%**	**66.4%**	**64.3%**	**50.9%**	**61.4%**

3.3.2 Long-waiting patients

Though the significantly increased activity after the COVID-19 pandemic, has ensured that the number of patients who have waited for 52 weeks or more on the waiting list remain high. The various waiting list initiatives implemented was beginning to make an impact.

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.

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



3.3.3 Quality Improvement (QI)

Quality improvement is key to improving the safety and effectiveness of the care we provide, and the experience our patients while using our hospital.

The focus of the last year has been on continuing to introduce and embed Appreciative Inquiry (AI) – a strengths-based, positive approach to encouraging and supporting innovation and learning. This has been embedded by the Patient Safety Specialists to learn from what goes well in the delivery of care to support the spread and adoption of good practice and to facilitate caring conversations with staff and patients who may have been involved in an event. QI projects use AI to involve staff and patients, to test ideas and pilots for change and to understand different perspectives to help improve quality. Quality Improvement has included educating and training teams on using Appreciative Inquiry in practice. Specific staff focus groups have patient experience teams to promote and increase positive practice.

We have introduced the CLEAR Pathway (Capturing and Learning from Everyday Experience) to capture examples of experiences and positive practice. Learning from Everyday Event (LIFE) sessions are held in the organisation to learn from patient stories. Patients have been involved with sharing their own stories which have been shared at Trust Patient Experience Board and Trust Board.

A head of quality improvement and quality improvement lead were appointed in the reporting year, who work with the existing quality, safety, experience and governance teams to continue developing and driving the improvement agenda.

QI strategy

A Trust QI strategy was introduced last year which sets out the ambition and vision for the organisation over the next 3-5 years. Initial adoption of the strategy is to build upon capacity and capability of staff with QI skills in the organisation.

Planning has commenced with incorporating Quality Improvement into the new National Patient Safety Strategy and Framework (PSIRF) which every healthcare organisation has to adopt by Autumn 2023.

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 continues to be developed as part of the Trust QI strategy.

This brings together the approaches in one virtual area, providing staff with 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.

The virtual improvement hub facilitates central capture of the improvement work being undertaken, to share and celebrate the small and large improvement work being delivered and enable reporting organisationally.

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.

Training

A Trust training strategy sets out the ambition and vision for the organisation over the next 3-5 years. A QI practitioner course commenced last year. Each member of staff who attends the QI Practitioner training is assigned a QI coach from the QI team to support them with their QI project.

There are training programmes for improvement across the Trust including QI Practitioner, Appreciative Inquiry, and Human Factors. In addition, there are QI modules within training sessions held with Preceptorship Nurses and the Trust MK Managers. Bespoke AI and QI sessions have been held with teams as part of away days.

Staff can also access online QI methodology training tools provided by Future Learn, NHS Elect and NHS England, and are provided with coaching and support from the QI team in using these tools in their improvement work at a team and individual level.

Systems, Processes and Sharing

Appreciative Inquiry-led systems have been embedded, including:

- 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 – LIFE sessions
- Reflective sessions on stories gathered

Next Year

Embedding the Quality Improvement Strategy for next year will continue to focus on building capacity and capability of staff trained in QI methodologies and to integrate the various QI methods (audit, Model for Improvement, GIRFT, NICE). A QI coach course will be introduced next year to develop the staff who have completed the QI practitioner course. Appreciative Inquiry tools will be incorporated into all QI projects to understand the patient/relative/staff perspective and to help understand whether improvement interventions are effective/beneficial.

3.4 Performance Against Key National Priorities

Indicator	Target and source (internal/ regulatory/other)	2017/ 18	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/ 23
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96% (National)	99.6%	99.2%	98.0%	94.5%	95.3%	95.3%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	85% (National)	88.2%	83.9%	81.1%	78.5%	70.6%	61.6%
Maximum wait of 2 weeks from GP referral to date first seen for all cancers	93% (National)	95.9%	96.4%	94.3%	84.1%	86.5%	77.1%
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments	98% (National)	100.0%	100.0%	99.0%	98.3%	98.8%	98.9%
Maximum waiting time of 31 days for subsequent cancer treatments: surgery	94% (National)	100.0%	98.9%	98.6%	84.2%	83.6%	80.8%
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients	93% (National)	96.0%	96.4%	97.5%	92.1%	96.8%	98.9%
Referral to treatment in 18 weeks - patients on incomplete pathways	92% (National)	90.7%	87.4%	85.5%	57.8%	52.5%	47.3%
Diagnostic wait under 6 weeks	99% (National)	99.0%	98.7%	98.9%	83.2%	64.5%	84.5%
ED treatment within 4 hours (including Urgent Care Service)	95% (National)	91.0%	91.4%	88.8%	93.1%	83.9%	79.1%
Cancelled operations: percentage readmitted within 28 days	95% (National)	67.0%	70.4%	86.5%	50.0%	74.3%	77.7%
Clostridium difficile infections in the Trust	10 (National)	13	15	14	6	13	19
MRSA bacteraemia (in Trust)	0 (National)	3	1	0	1	1	2

Appendix 1

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

Quality Account 2022 – 2023

BLMK Integrated Care Board acknowledges receipt of the draft 2022/2023 Quality Account from Milton Keynes University Hospital (MKUH) and welcomes the opportunity to provide this statement.

The Quality Account was shared with BLMK's Executive Directors, Commissioners and Quality Team and systematically reviewed by key members of the ICB's Quality Team as part of developing our assurance statement.

2022/23 has continued to be a very challenging year for the system, with the on-going impact from new COVID-19 variants, system wide pressures and recent national industrial action all whilst working towards recovery of services affected by the pandemic. It is positive to see that all system partners across the Integrated Care System (ICS) are continuing to adapt and develop to deliver safe care to our patients, both at Place and across the wider ICS footprint. We would like to extend our gratitude to staff for their commitment and hard work during this time.

The Quality Account is a well-constructed document which clearly evidences the improvements, innovations, and challenges during the year along with areas of focus for 2023/2024

Throughout 2022-2023, MKUH have continued to demonstrate their commitment to adopting new and innovative technologies aimed at improving the provision of services and quality of care. This has included converting patients to digital access using their single, secure NHS login to access their MyCARE patient portal. Also on the technology front, the Versius surgical robot has now completed its 500th case, which is a wonderful landmark and continues to demonstrate MKUH's position as one of the national frontrunners in the area of robotics in the treatment and care of patients, helping to deliver very high levels of surgical precision and control by surgical staff.

We appreciate the amount of work being undertaken to implement all relevant requirements within the National Patient Safety Strategy, and in particular the transition from the National Serious Incidents Framework to the Patient Safety Incidence Response Framework. We look forward to continuing to work with the Trust on this important work to ensure patient safety is at the heart of organisational culture.

The ICB is supportive of the Trusts 2023/2024 Quality Account priorities, some of which will build on the 2022/23 priorities and others that aim to further improve effectiveness and patient experience. All of which align with national and local safety data.

The first priority, reducing deep tissue injuries (pressure ulcers) is an area that has the potential to provide significant improvements in patient safety. This supports work that is already ongoing within the Trust as a result of increasing numbers in the previous year.

The second priority, improving sepsis management, will improve the effectiveness of the treatment of patients.

The third priority, improving reporting rates of low harm events, will improve patient safety and also improve the experience of patients while providing them with effective of treatment.

For 2022/23 Milton Keynes University Hospital fully participated in the National clinical audit's programmes, with some key learning identified. This together with continued research activity has demonstrated a clear commitment to improve patient outcomes and experience across the NHS. This activity should be commended against the ongoing pandemic challenges.

Whilst elective and cancer care recovery are not identified as Quality Account priorities The ICB are aware of the continued work being undertaken particularly within diagnostic and imaging services.

The cancer centre that opened in 2020 has supported ongoing work to improve local services. A new build will provide radiotherapy services locally and is due to open in 2024.

It is clear that MKUH are committed to listening to staff about concerns and issues. There is clear support from the Chief Executive Officer and Trust Board lead for Freedom to Speak Up. The Trust has a comprehensive and accessible Speaking Up Policy which supports how colleagues can raise concerns with the FTSU Guardians and Champions and ensures that confidentiality is afforded to those individuals as a matter of course.

BLMK ICB wishes to acknowledge the achievements made during an extremely challenging 12 months and can confirm, to the best of our knowledge, that the Quality Account contains transparent information which is factually accurate and identifies areas of practice for improvement that the ICB continues to support in relation to the range and quality of services provided. The information provides both positive achievements and opportunities for improvement.

We hope the Trust finds these comments helpful and look forward to continuous improvements and collaborative working throughout the coming year.

Signed:

Sarah Stanley,
Chief Nursing Director BLMK Integrated Care Board

Appendix 2

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7th June 2023

Healthwatch Milton Keynes response to Milton Keynes University Hospital NHS Foundation Trust Quality Account 2022-23

Healthwatch Milton Keynes (HWMK) would like to thank Milton Keynes University Hospital NHS Foundation Trust (MKUH) for inviting us to comment on the draft Quality Account 2022-23.

Healthwatch Milton Keynes asks resident volunteers to participate in the annual review of Quality Accounts on our Quality Account Panel. Our volunteers offer a unique perspective that staff within Healthwatch might overlook because they have good knowledge of local health systems and services. This year our panel had 7 members – 5 volunteers, 2 trustees and 1 member of staff.

The QA panel felt that generally speaking, this Quality Account is not effective at providing a way for residents to form a view about how well the Trust is performing in relation to Quality. Whilst the report is interesting and contains a significant amount of information about quality there is no real flow or structure to the report which makes the report difficult to follow. We felt that there are three key issues with the Trust's Quality Account that contribute to the lessening in relevance to members of the public:

- **Accessibility** – Some parts of the QA are easier to read than others, but plain language is lacking. There are many acronyms, too many technical terms and jargon which require a glossary or linked jargon buster.
- **Poor information about failures, performance, outcomes and comparisons** – The Account has a promotional and descriptive narrative with little evidence to demonstrate that the organisation is measuring and learning from failure and has a strong performance and improvement framework. Much emphasis is placed on inputs instead of tangible outcomes between reporting periods.
- **Absence of evidence of improvement that has directly resulted from patient feedback** – There is very little in relation to engagement with patients about service improvements and there is no picture of what the Trust's commitment is to engaging with patients in a structured way.

Priorities for improvement in 2023-24

The panel noted that ***priority 1 – reducing deep tissue injuries (DTIs)*** remains an improvement priority for the third consecutive year. When comparing MKUH's 2022-23 and 2021-22 Quality Accounts it appears that the number of deep tissues injuries decreased by 18% between 2020-21 and 2021-22 but subsequently increased by 244% between 2021-22 and 2022-23. It is concerning that whilst there is narrative about how improvements will be monitored and reported, there is no clear explanation about the data, and in particularly the significant increase in reported DTIs. DTIs clearly remain a persistent issue for patients and the hospital, to the extent it requires prioritisation for three consecutive years. This warrants a clear rationale and more detail about the initiatives implemented within the hospital to reduce DTIs, as well as the challenges in achieving a reduction to DTIs.

Priority 2 – Improvements in sepsis management and ***priority 3 – improvements in the reporting rates of low harm events*** are important safe practices to prioritise. However, the detail around what changes will be made, or implemented is vague and quite heavy in health service jargon. It is important that Quality Accounts are easy to read and understand by patients using the hospital.

Trust performance against Priorities for Improvement in 2022-23.

The HWMK QA panel felt that there was insufficient detail against ***priority 1 – Reduction in deep tissue injuries (pressure ulcers)***. Whilst we recognise that Quality Accounts, like other forms of required reporting can be time consuming for providers to complete, it reflects poorly on the approach of Trust and its recognition of the work of the staff within the hospital when patients are not able to see the story – the commitment and dedication to improving their safety and care within a Quality Account.

Similarly, ***priority 2 – Improvements in (elective care)*** to reduce long waiting times lacks detail to help the reader to understand what the plan was, why it didn't work and the rationale for why an issue that has continued to get worse be de-prioritised. The QA panel felt that the Hospital's plan to reduce the number to zero by month 12 was ambitious and unrealistic given the numbers shown on the graph for 2021-22. Data can be a challenge to present but in order to build trust with patients and communities it is important to explain data and detail the actions being taken to achieve a reduction in waiting times.

With regards to reporting against ***priority 3 – Reductions in discharge delays*** the QA Panel again commented on poor detail of any actions taken by the Trust to address the priority. There is no explanation about the rationale for de-prioritisation and how continuous improvement has been embedded into practice. We feel this was a key opportunity for the Trust to detail the work it is undertaking with the Milton Keynes Health and Care Partnership and other health and social care providers to redesign care pathways that aim to reduce delayed discharges.

CCG8 under the ***2022/23 CQUINs for Milton Keynes University Hospital NHS Foundation Trust:*** Whilst not a target set by the Trust itself, we have concerns about the metric (Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending). We feel that 70% is an unacceptable marker of quality. The panel recommends that the Trust add information about whether it had exceeded this target, over and above 70%. This was felt of particular pertinence in relation to the effects of poor mobilisation on DTIs and patient deconditioning which can result in poorer outcomes for patients, and delayed discharge.

We also have concerns about the CQC ratings of ED and surgical and would like to see what is in place to improve, particularly in relation to the Trusts strong focus on quality improvement.

As one of the quality markers withing Quality Accounts is improving patient experience we recommend that the Trust expand further on its patient experience initiatives. We have noted the innovative approaches taken in developing and embedding Appreciative Inquiry (AI) and in developing the CLEAR Pathway, especially the inclusion of patients and look forward to seeing the results of evaluation of these initiatives. However, while we were pleased to see the detailed information on safety initiatives and complaints mechanisms, in line with the obligatory sections of the report, we were surprised not to see more mention of the positive actions taken to further patient involvement in co-production, decision making and in improving patient experience while attending or staying in the hospital.

Beyond the Quality Account itself, the QA Panel noted that the Trust, through the Council of Governors, has worked hard to reinvigorate the work of the Trust's governors, providing new public and patient engagement strategies and opportunities to capture public interest in the work of the Trust. The Quality Account is an opportunity to engage the public in exactly this. Developing future QAs with a patient and public focused approach is essential.

We were concerned about the generally critical position they made of the MKUH's 2022-23 Quality Account. Whilst it is the statutory function of local Healthwatch to provide constructive and independent feedback, volunteers are members of their community, and they want to see health services at the heart of their community trusted by patients and thrive. Whilst recognising that Quality Accounts are just one way of residents and patients understanding how their local hospital works to improve their care, they are nonetheless essential in providing an open, transparent and understandable picture of what the hospital does to improve patient safety, improve quality and patient experience.

We finally wish to commend the Trust on its achievements in advancing technologies to improve care and quality, as well as key developments in the Trust's services including the Cancer Centre, Maple Unit, Radiotherapy Unit and Women and Children's Hospital. The Trust has achieved an excellent reputation in the use of technology to improve quality of care and patient safety, and we would like to see its innovative approach well monitored and evaluated to guide future development. From the HWMK point of view, this is particularly true of the MyCARE patient portal and the mobile version of the FFT platform, in relation to patient access across all groups (including those without smart phones). We would also like to see more information on data access, exchange and interoperability, including inter- communication with other Trusts and ICSs.

We very much appreciate the opening of the new Maple Centre, providing dedicated space for both medicine and surgical Same Day Emergency Care (SDEC) pathways to the population of Milton Keynes. This does a great deal to improve access to hospital services for primary care.

We have been very pleased to see the extensive work undertaken in cancer treatment, especially the collaborative approach taken. The new Cancer Centre is very central to this approach, and we are encouraged by the work now in progress on the radiotherapy unit. It is good to note that the cancer patient experience survey from 2022 saw MKUH placed in the top quartile of the country for good patient experience with an overall score of 8.9 out of 10.

Healthwatch Milton Keynes thanks Milton Keynes University Hospital Foundation Trust for presenting their draft Quality Accounts for 2022-23.

Kind regards

Maxine Taffetani
Chief Executive Officer
Healthwatch Milton Keynes

Appendix 3

Milton Keynes NHS Foundation Trust Quality Account 2022/2023

On behalf of the Central Bedfordshire Social Care, Health and Housing Overview and Scrutiny Committee, I would like to thank The Milton Keynes NHS Foundation Trust for the services it continues to deliver to our residents. With a mostly new look Committee elected in May 2023, we look forward to working constructively with the trust to support the scrutiny process and our residents.

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

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