Milton Keynes Hospital NHS
NHS Foundation Trust

To be added: Chief Exec signature; OSC statement; AnnexB signatures

Milton Keynes Hospital NHS Foundation Trust

Quality Accounts and Report 2010-11

Contents

PART ONE - A Statement on Quality from the Chief Executive

What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare about the quality of services they deliver. By putting information about the quality of services in an organisation into the public domain, an organisation is offering up its approach to quality for scrutiny, debate and reflection. All providers of NHS Services, no matter how large or small, or what services they provide, should be striving to achieve high quality care for all and, therefore, all are required to produce a Quality Account as set out in the Healthcare Act 2009 and supporting regulations.

This report assures the public that Milton Keynes Hospital NHS Foundation Trust has examined the quality of all of its services and highlighted areas where we have done well and areas that we have identified where improvement is required; these are highlighted as our 'key priorities'. We include updates on our progress against the 'key priorities' we chose last year and provide information about our new 'key priorities' for this year (2011 – 2012).

What are the Trust's Commitments to Quality?

Milton Keynes Hospital NHS Foundation Trust is dedicated to delivering a quality service to our population. The Trust is committed to:

- treating our population well;
- meeting their needs; and
- growing with Milton Keynes.

We aim to do this by:

- developing our capacity to deliver excellent services;
- investing in our services to deliver the best performance;
- delivering more health services closer to home for more people where it is clinically appropriate and safe to do so;
- providing excellent-quality services which exceed our patients' and commissioners' expectations; and
- enhancing our reputation.

Looking back and reflecting… In summary
2010 – 2011 Key Priorities

Improve the quality of maternity services

- In October 2010, the Care Quality Commission lifted 9 of the 12 conditions from the hospital's registration following the regulatory action taken against the Trust in March 2010.
  To note: although too late to record within the 2010-11 quality account CQC lifted the final three conditions on 7th April 2011;
- We have provided one-to-one care for women in established labour since April 2010;
- We have recruited more midwives;
- We have increased normal birth rates and reduced caesarean section rates; and
- The Maternity Monitoring Panel's report was positive about the improvements we had made.

Reduce healthcare associated infection rates

- The Trust has achieved a low rate of healthcare associated infections (C Diff 33, MRSA 2);
- Investigation into cases of MRSA Bacteraemia and C Diff is shared across the Trust and the Community Infection Prevention and Control Teams;
- Antibiotic use remains under constant scrutiny to ensure appropriate prescribing;
- Older and more vulnerable adults are offered a pro-biotic drink to encourage healthy gut flora; and

- The red jug and red mug project has helped to reduce the use of urinary catheters with the potential risk of infection.

Improve the experience of patients using the hospital

- We have improved our clinical governance systems that ensure quality care is provided;
- Key Performance Indicators show a reduction in complaints on last year; 97% of patients surveyed reporting that they felt involved in decisions about their care and treatment; a reduction in the number of single sex accommodation breaches;
- The Trust met in full the CQUIN for Patient Experience demonstrating positive feedback via our Internal Inpatient and Outpatient Exit Surveys;
- We improved our arrangements on ward areas to ensure same sex accommodation for our patients;
- We improved help being available for patients at mealtimes; and
- We improved our provision of discharge information to our patients.

Please note: More detailed information on how we progressed against last year's priorities is given in section two of this report.

2010-2011: a year of successes and challenges

Milton Keynes Hospital NHS FT performed strongly in 2010-11 across a range of areas (detailed in Parts 2 and 3 below), working in partnership with our commissioner NHS: Milton Keynes to develop and deliver improving and patient-centred services.

However, we continued to face difficult challenges around our maternity services but have worked hard to improve our services and to recruit more midwives.

Our problems with maternity services and other trust-wide governance issues were reflected in conditions on our registration with quality regulator the Care Quality Commission and we have worked hard to make the improvements required to get these conditions lifted during 2010-11.

We do understand that the past problems with our maternity services have a negative effect on people's perceptions of the quality of care we provide; but we do think the efforts we have made this year are positively impacting on this as the feedback we have received from the people that use our services reflect this.

Continuing to improve maternity services is one of our top priorities for 2011 and beyond.

Finance Section

The Trust will be facing some particularly complex challenges in 2011 and beyond. During 2010 inefficiencies within the Trust compounded by rising costs and reduced income resulted in financial deficit. We have been working hard to correct this situation, but things won't get any easier in the coming months, as public spending gets squeezed.

We believe there are some things we can be doing to make our work more efficient. Things like making our systems run more smoothly and cutting out any unnecessary delays, so that patients can be discharged as soon as they are well enough. Not only does this free up beds, it is also better for patients. People don't want to stay in hospital any longer than they have to.

In all the changes patient safety must not be compromised. To ensure this the Trust has revised and strengthened its governance structures ensuring that Clinical Directors are at the heart of monitoring and assurance processes so that early indicators of any reduction in quality or safety can be acted upon swiftly.

Performance against national priorities

18 Week Referral To Treat (RTT) pathways

The Trust met the aggregate 18-week standards for both admitted (91.7%) and non-admitted (99%) patients for Quarter 4. However, individual specialties did not meet the admitted patient targets, and one the non-admitted target over the Quarter, as listed below.

Admitted

Orthopaedics failed to reach 90% for admitted patients, achieving 82.4% for Quarter 4.

Urology failed to reach 90% for admitted patients achieving 82.6% for Quarter 4

Non-admitted

Thoracic medicine failed to reach the 95% for non-admitted patients, achieving 94.5% for Quarter 4.

The positives

A new system introduced to the NHS in 2009-10 now makes an element of payment dependent on delivering agreed quality of services under the Commissioning for Quality and Innovation (CQUIN) initiative. The table below indicates the final position on the CQUIN scheme 2010–11.

CQUIN Scheme	Possible Achievement	Actual Achievement
Venous Thromboembolism (VTE)	£207,227	Not achieved
Patient Experience	£207,227	£207,227
Heart Failure (Improving Quality Programme IQP)	£69,076	£69,076
Acute Myocardial Infarction (IQP)	£69,076	£69,076
Pneumonia (IQP)	£69,076	£69,076
Hip and Knee (IQP)	£69,076	£69,076
Pressure Ulcers	£207,227	Not achieved
Normal Births	£234,857	£234,857
Stroke	£234,857	£234,857
Diabetes	£234,857	Not achieved
Nutrition	£234,857	Not achieved
Emergency Department Data Sharing	£234,857	£176,143
TOTAL	£2,072,270	£1,011,959

The Trust fully achieved 6 and partially achieved 2 out of a possible 12 CQUIN schemes this year. Whilst the Trust was disappointed at not fully achieving (4 of the 12 CQUINs were not achieved), learning outcomes from these schemes are being implemented within our engagement arrangements for the 2011-12 CQUIN Schedule to ensure continued improvements reflecting our dedication to providing safe and high quality of care for our patients.

Quality of care is our highest priority

Quality of care is the chief concern of our patients, our community and of our commissioner NHS: Milton Keynes. It is our top priority as well.

The Trust has worked hard and continues to do so to ensure the ongoing improvement for our clinical governance arrangements so that we can be confident that we are a learning organisation with strong and effective clinical leadership – an organisation that can:

- identify when things are going well and developing, and
- ensure that we spot quickly when things do not go well;
- and that we learn the lessons to prevent repetition.

To do this, we work in an open and transparent way to ensure that the relationship of trust with our community remains healthy. A new Patient, Public and Staff Experience Committee was convened

during 2010-11 to facilitate and strengthen the Trust's ability to listen, reflect and take action where required. The community's input has helped us make significant changes and improvements in 2010-11. For example, in response to the feedback we have received we have changed visiting times in hospital and re-launched protected mealtimes.

Our Clinical Quality Review Group reviews agreed measures of clinical quality with our commissioner NHS: Milton Keynes against a quality schedule (including national indicators of commissioned quality and innovation (CQUINs) every two months.

Board meetings focus on safety issues for two-thirds of every meeting: it is the primary concern of the Board. To reinforce this, the executive directors of the Trust now regularly do 'Patient Safety Walk-rounds' of the wards with their non-executive director counterparts on the Board, to see for themselves how care is being delivered.

We are also grateful for the important work of our Council of Governors, and for the efforts of our Local Involvement Network (LINk), with whom we are building better communication.

Financial matters

Although the Trust saw only moderate growth in 2010-11 the financial result saw a much increased cost base leading to the £6.2m deficit.

The one-to-one care ratio of midwives to mothers in established labour meant an increase in costs as the Trust employed additional agency staff at premium rates while implementing a rolling recruitment process for substantive midwives.

Additional governance costs were incurred in the year; these covered a review of Board effectiveness and the maternity CQC registration issues as well as the costs to implement the Transformation Plan.

The Trust completed its capital expenditure on the Eradication of Mixed Sex Accommodation during the year and implemented Electronic Document Management meaning that patient records are updated in a more timely fashion and available faster for appointments. Development work will continue into 2011-12 on maternity and the neo-natal unit.

Working with the community

We recognise that changes in healthcare are driving the NHS to providing more care in community non-hospital settings. Our commissioner NHS:Milton Keynes has outlined their plan to reduce the level of activity they buy from us next financial year.

We know that this means developing and improving our communication and hand-over of care with GPs and with community providers. It also means more effective data provision to our commissioners about our activity and outcomes.

We are committed to making significant progress with all of this in 2011and beyond. We are also determined to continue our progress with listening to our commissioners, community, patients and staff about how we can improve.

We are determined both to learn from our challenges and to celebrate our successes. We have no room for complacency. We are proud of our hard-working staff.

We are determined to provide the best-quality healthcare we can for our population in 2011-12 and beyond.

What are the Quality Improvement Priorities for 2011-12 and why were they chosen?

The priorities we have chosen reflect some of the priorities within the NHS Outcomes Framework which is split into five domains encompassing the three aspects of quality as defined by consultant surgeon and former health minister Lord Darzi. These are:

- clinical effectiveness,
- patient safety, and
- patient experience.

Our priorities for 2011-12 are set out in full in Part Two of this report. In brief these are:

Clinical Effectiveness

1. **Enhancing quality of life for people with long-term conditions and helping people to recover from episodes of ill health or injury.**
   This will include reviewing and improving our care for the elderly, our care of patients with chronic illness and dementia, for those with learning disabilities, and end of life care.

Patient Safety

2. **To continue to improve the quality of maternity services**
   It is important that we continue to grow the improvements we made in this area last year.

3. **Treating and caring for people in a safe environment and protecting them from avoidable harm.**
   It is important that we continue to ensure that we provide a safe environment for the people who use our services as well as for the people who work within it to ensure they are protected from avoidable harm. We will continue to maintain our excellent record of infection prevention and control and our low rate of hospital acquired infections.

Patient Experience

4. **Ensuring people have a positive experience of care**
   We will do this by improving our communication with patients and the care pathways we have with other healthcare providers, and by improving the documentation of clinical decisions so that patients can be more informed about their care and options available to them.

Who has been involved in developing the Quality Account?

Consultation is key to the successful identification of progress made, and other key priorities for focus in the coming years, and therefore the Trust produced a Project Plan outlining the development and consultation process for the account which was approved by the Trust's Quality Committee in November 2010 to ensure involvement of the following people, committees or groups:

- Our Patients, their families and friends via feedback nationally and locally through surveys, complaints and compliments;
- Our Staff, via national and local surveys; reporting of incidents, the investigation of these and outcomes for shared learning;
- Our internal Governance Boards, Committees and Groups (which include representatives from Medical, Nursing, Allied Health Professional and Management teams) who have analysed this information and made decisions for quality improvement initiatives where required;
- Our commissioners NHS: Milton Keynes who we work with to develop our Quality Schedule which forms part of out Provider Contract; and
- Organisations in the Community who advocate for patients who may use our services.

Key Quality Performance Indicators outlined within our Quality Account during 2010–11 have been regularly reported on Score cards to our Trust Board and our Commissioners and this practice will continue for 2011-12 with the development of further Score cards designed for use at the frontline of services.

Statement of Assurance

This report has been reviewed by the Board of Milton Keynes Hospital NHS Foundation Trust. The Chief Executive is the responsible officer and I sign to state that, to the best of my knowledge, the information contained in this report is accurate.

Signature to insert once approved

Mark Millar
Interim Chief Executive
1st June 2011

PART TWO - Priorities for Improvement

Our priorities for 2011-12

Our priorities for 2011-12 are defined in their broadest sense within the NHS Outcomes Framework and reflect the three key aspects of Quality as defined by Lord Darzi; these being clinical effectiveness, patient safety and patient experience. These priorities and the key work-streams within them were shared with all stakeholders across the health economy to ensure they felt we had got our priorities right. Stakeholders include:

- Our Patients, their families and friends via feedback nationally and locally through surveys, complaints and compliments;
- Our Staff, via national and local Surveys; reporting of incidents, the investigation of these and outcomes for shared learning;
- Our internal Governance Boards, Committees and Groups (which include representatives from Medical, Nursing, Allied Health Professional and Management teams) who have analysed this information and made decisions for quality improvement initiatives where required;
- Our commissioners NHS:Milton Keynes who we work with to develop our Quality Schedule which forms part of out Provider Contract; and
- Organisations in the Community who advocate for patients who may use our services.

Clinical Effectiveness

1. **Enhancing quality of life for people with long-term conditions and helping people to recover from episodes of ill health or injury.**
   This will include reviewing and improving our care for the elderly, our care of patients with chronic illness and dementia, for those with learning disabilities, and at the end of life by:
   - Ensuring patients receive care in the most appropriate place;
   - Ensuring the safety and wellbeing of those patients who are less able to protect themselves from harm, neglect or abuse, for example due to impaired mental capacity, physical or learning disability or frailty brought about by age;
   - Ensuring that there is evidence of advance care planning where patients who are at the end of their life are given opportunity to voice their preference for their preferred place of care and death;
   - Ensuring that all is done to reduce the risk of patients falling in hospital and to reduce the severity of harm caused to patients as a result of a fall in hospital; and
   - Ensuring that all adult patients have an individual nutritional assessment within 48 hours of admission (using MUST, a nationally validated tool).

   Key Performance Indicators we will use to measure our success include:
   - (CQUIN) Patient Experience which will include information our patients have provided to us via the National Inpatient and Outpatient Surveys along with the results of the Trust's own Inpatient and Outpatient Exit Surveys;
   - (CQUIN) Pressure Sores;
   - (CQUIN) End of Life Care;
   - (CQUIN) Vulnerable Adults;
   - (CQUIN) Care of Patients in the most appropriate setting;
   - (Quality Schedule) Infection Prevention and Control targets;
   - (Quality Schedule) Transfer of Care;
   - (Quality Schedule) Efficient Handover of care between the Emergency Department and the Ambulance Service;
   - (Quality Schedule) Patient Falls;
   - (Quality Schedule) Nutritional Assessment for all patients;
   - (Quality Schedule) Stroke Care

   To note, details of the Key Performance Indicators linked to CQUIN and the Quality Schedule available on request.

Patient Safety

2. To continue to improve the quality of maternity services

The 2011-12 priorities for maternity services will be to sustain and improve the highest standards of quality and safety that keep pace with changing demographics and rising birth rates at a time of increasing financial constraints and focus on efficiencies and productivity.

The overall aims of the Maternity Strategy for Milton Keynes Hospital NHS Foundation Trust are:

- Assuring the effectiveness and quality of care;
- Defining and valuing the workforce;
- Creating and sustaining innovation and effectiveness;
- Promoting and valuing patient and public involvement;
- Creating and developing the infrastructure and environment; and
- Agreeing robust commissioning and financial sustainability.

Against a backdrop of ensuring effective, efficient and productive ways of working our objectives to improve productivity and quality outcomes for 2011-12 include:

- The implementation and completion of a Leadership Development Programme focused on clinical decision making and effective multi-disciplinary team working;
- Facilitation of a senior team away day to strengthen working relationships;
- To demonstrate our commitment to breastfeeding standards by obtaining Certificate of Commitment to Baby Friendly Initiative and demonstrate progression to UNICEF Baby Friendly Accreditation;
- The development and implementation of a maternity triage service to streamline access to improve outcomes by lowering risk to women by having clear pathways for communication and referral;
- Rationalise unscheduled antenatal care and determine efficiencies in antenatal care pathways;
- Further develop team caseload models of midwifery care to optimise continuity of care that offer benefits in terms of outcomes and patient experience;
- To progress work and develop an action plan to achieve CNST Level II status;
- Review and development of clinical data systems to improve robustness of data collection and documentation in line with Trust EDM project;
- Effective implementation of Service Line Reporting management structure; and
- Continue to demonstrate one-to-one care in labour and driving normalising birth and reducing caesarean section rates.

Key Performance Indicators we will use to measure our success include:

- (CQUIN) Patient Experience which will include information our patients have provided to us via the National Inpatient and Outpatient Surveys along with the results of the Trust's own Inpatient and Outpatient Exit Surveys;
- National Maternity Survey;
- (Quality Schedule) Infection Prevention and Control targets;
- (Quality Schedule) Smoking cessation;
- (CQUIN) Normalising Birth.

To note, details of the Key Performance Indicators linked to CQUIN and the Quality Schedule available on request.

3. Treating and caring for people in a safe environment and protecting them from avoidable harm.

In 2010-11, the Trust achieved steady progress across the year in reducing the number of avoidable health care associated infections. Our commitment grows stronger in the face of the challenges identified for 2011-12 and beyond. The national policy is driving ever tighter requirements, and patients rightly expect to be treated in safe, clean environments.

We will further broaden our remit to provide a greater focus on the environment of the whole Trust, culturally as well as physically, to:

- improve the sense of security and confidence patients have in the care they receive;
- improve the working environment for all staff;
- advance team working within and across teams in the trust and with our colleagues in the community;
- ensure that data reporting becomes a seamless and straightforward part of the everyday delivery of care; and
- ensure that we link best use of resources to the way we deliver clinical care.

Good Infection prevention and control is central to the delivery of safe and cost effective healthcare. It has a unique place in our hospital in that it impinges upon all aspects of healthcare delivery. Working arrangements in the Microbiology Laboratory have been established to facilitate seven-day testing and reporting for *Clostridium difficile* toxin and *Meticillin resistant Staphylococcus aureus* (MRSA) colonisation and bacteraemia. MRSA rapid identification technology (PCR) has been introduced to improve turnaround time and patient management.

An enhanced MRSA screening programme was launched on March 31st 2010, with all patients requiring emergency admission to our hospital being offered an MRSA screen. For the maternity unit this meant a considerable shift in practice from offering `Mums at risk` an MRSA screen, to all pregnant women. This builds on our work undertaken from April 2009, where the majority of patients coming for planned operations were MRSA-screened as per the Department of Health guidance.

We expect our activity throughout the coming months to further reduce HCAI rates and where possible, to exceed statutory and mandatory HCAI targets, firmly establishing the hospital as a centre of Infection, Prevention & Control (IPC) excellence.

Key Performance Indicators we will use to measure our success include:

- (Quality Schedule) Infection Prevention and Control targets;
- (CQUIN) Patient Experience which will include information our patients have provided to us via the National Inpatient and Outpatient Surveys along with the results of the Trust's own Inpatient and Outpatient Exit Surveys.

To note, details of the Key Performance Indicators linked to CQUIN and the Quality Schedule available on request.

Patient Experience

4. Ensuring people have a positive experience of care

We will do this by improving our communication with patients; improving the care pathways we have with other healthcare providers; and by improving the documentation of clinical decisions so that patients can be more informed about their care and options available to them.

One of the Trust's top priorities has always been to focus on how to improve our services to our patients by listening to concerns and feedback from service users.

Over the past year, the Trust has engaged different methods to successfully collect patient views and responses on how we can continuously improve the patient and public experience at the hospital.

The Trust now has a Patient, Public and Staff Experience Committee, which started in the summer of 2010. It has drawn its membership not only internally but from the Council of

Governors, LiNKs, and the Cancer Network Partnership. The committee has a work plan which is now in full flow, areas that are being reviewed include:

- Inpatient care of patients with Parkinson's Disease;
- End of Life Care; and
- Communications with our patients and relatives.

Ensuring our patients feel informed about their care and treatment has also been high on the Trust agenda this year and as a result the Matrons have undertaken audits to ensure information is conveyed to patients in a way that enables patients to make informed decisions about their care and treatment pathway.

'Patient Panels' have been very successful. Their achievements have shown that by working in partnership with hospital staff, with each listening to the other, small numbers of committed patients can make a difference to the service offered to all; an example of this is the Outpatient User Group established to improve the experience of service users who come to the hospital to see a specialist. All of this work pursues the aims of:

- Viewing the whole patient journey with the team of people involved in the patient's care to identify what is of value to the patient; and
- Making the process flow for the patient, i.e. reducing queuing and waiting time.

It is imperative that Milton Keynes Hospital is continuously collecting feedback from their patients on a regular basis to ensure the quality of service patients receive is consistently high. To do this, each patient receives an exit questionnaire when they are discharged; any comments or suggestions are passed back to the relevant ward sister or charge nurse to promote and action improvements.

The Trust is committed to provide single sex accommodation for our patients; this is monitored by the Trust Board on a monthly basis. New guidance has recently been given directly from the Chief Nursing Officer via the Department of Health. To this end the Trust has taken note of this guidance and has reviewed its Single Sex Accommodation policy to ensure it abides by any additional recommendations made.

Patients will only be placed in a mixed-sex sleeping area when it can be clinically justified; for example where patients need specialist equipment such as in the critical care and coronary care departments (where the intensive nature of their care determines that for clinical observation purposes, male and female patients may share these areas), or when patients themselves choose to share.

Key Performance Indicators we will use to measure our success include:

- (CQUIN) Patient Experience which will include information our patients have provided to us via the National Inpatient and Outpatient Surveys along with the results of the Trust's own Inpatient and Outpatient Exit Surveys;
- (CQUIN) Pressure Sores;
- (CQUIN) Venous Thromboembolism;
- (CQUIN) End of Life Care;
- (CQUIN) Vulnerable Adults;
- (CQUIN) Care of Patients in the most appropriate setting;
- (Quality Schedule) Infection Prevention and Control targets;
- (Quality Schedule) Transfer of Care;
- (Quality Schedule) Efficient Handover of care between the Emergency Department and the Ambulance Service;
- (Quality Schedule) Patient Falls;
- (Quality Schedule) Nutritional Assessment for all patients;
- (Quality Schedule) Stroke;

- (Quality Schedule) Emergency Department targets;
- (Quality Schedule) Eliminating Mixed Sex Accommodation
- (Quality Schedule) Smoking cessation;
- (Quality Schedule) Cancer Services;
- (Quality Schedule) Surgical Services.

To note, details of the Key Performance Indicators linked to CQUIN and the Quality Schedule available on request.

How will we monitor performance?
Our progress on our priorities for 2011-12 will be regularly monitored by our Trust Board via Quality Scorecards which reflect key performance indicators of quality (as listed under each 'key priority'), which key work streams influence, and by Governance Committees and Groups within the organisation with an expertise or responsibility for a particular Quality Requirement. Progress will also be measured in a report we will prepare for the quarterly meetings of the Members' Council. This will afford our partners in the Local Involvement Network (LINk), our commissioner NHS:Milton Keynes and Milton Keynes Council regular opportunities to discuss progress and give us feedback. We will also publish it on our website.

Volunteers
Voluntary workers are an integral part of part of the team. Milton Keynes Hospital is fortunate enough to have approximately 300 hospital volunteers and 100 volunteers in the community who undertake a wide range of roles within wards, departments, welcome desks and snack bars to complement and support the work of the Trust's paid staff.

Our voluntary workforce makes an enormous positive impact on the care that the hospital has delivered over the past 25 years. They are an incredibly valuable asset to Milton Keynes Hospital. Whether directing visitors, serving refreshments on the wards, organising paperwork or simply offering a friendly ear to a patient, their help makes a very real difference. Our volunteers can help from two hours a week to as many hours as they can spare. We have a variety of roles, and can usually find something that fits in with the lives and interests of the individual. Our staff value voluntary workers as an integral part of part of the team.

This year, Trust staff have worked with our volunteers to develop the meal time assistant, these are volunteers who are trained to help patients with their meals, this initiative (protected mealtimes) is part of ensuring that mealtimes are taken as an important part of a patient's stay in hospital. Not only are we providing additional support for those that need it but the time when food is served and eaten is kept protected which means patients will not be disturbed by routine tasks from Healthcare professionals.

Statements Relating to Quality of NHS Services Provided

Review of Services
During 2010-11 Milton Keynes Hospital NHS Foundation Trust provided and/or subcontracted 37 NHS services.

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

The income generated by the NHS services reviewed in 2010-11 represents 100% of the total income generated from the provision of NHS services by Milton Keynes Hospital NHS Foundation Trust for 2010-11.

Participation in Clinical Audit and National Confidential Enquiries

During 2010-11 23 national clinical audits and three national confidential enquiries covered NHS services that Milton Keynes Hospital NHS Foundation Trust provides. This section details our participation in these.

During 2010-11 Milton Keynes Hospital NHS Foundation Trust participated in 74% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

National Confidential Enquiries

The Trust has participated in the following studies:

- Surgery in children (Data collection still ongoing);
- Peri-operative care for elderly patients following surgery (Date collection still ongoing); and
- Cardiac Arrest Procedures (Data collection still ongoing).

The Trust has reviewed all applicable National Confidential Study Reports published this year and has developed action plans to address areas where a change in practice is required. These include:

- Parenteral Nutrition – 'A mixed bag' (2010) – An enquiry into the care of hospital patients receiving parenteral nutrition; and
- Elective and Emergency Survey in the elderly – 'An old age problem' (2010).

National Audit Programme

During 2010-11 the Trust participated in the National Clinical Audit and Patient Outcomes Programme. Information regarding these audits can be found in Appendix 1 – Participation in Clinical Audit.

The reports of 239 clinical audits, including national ones, were carried out by the provider in 2010-11. Audits are reviewed in departmental audit or clinical improvement group meetings as per the Trust's Clinical Audit and Effectiveness Strategy, actions are not centrally collated but where risk assessment indicates further escalation, recommendations are shared for organisational learning within the departmental meetings Trust wide and concerns escalated via the Clinical and Corporate Governance Committee and Group Structure for further decision making.

Audits presented to Trust Board

Results of Trust wide Priority Audits have been presented to Trust Board or to the Quality Committee a sub-committee of the Trust Board. During this period these have included:

- Hand Hygiene Audit results are presented monthly as part of the Matrons' report;
- Internal In-patient and Out-patient Exit Surveys;
- National In-patient Survey;
- Patient Discharge;
- National Staff Survey;
- Venous Thromboembolism;
- Trust Documentation Audit; and
- Early Warning Score Chart documentation audit.

Clinical Governance Plenary Sessions

The Trust conducts Clinical Governance Plenary afternoon sessions each month which enable protected time for clinicians to review clinical quality and patient safety audits and healthcare evaluation. Topics include audits on areas which have been triggered as high risk and may have been related to a serious incident and /or complaint. Presentations during 2010-11 have included:

- Recognition and Management of Sepsis – Presented by Dr Ron Daniels, an external speaker who is Director of the Survive Sepsis Campaign;
- Medication Incident Reporting;
- Peripheral Cannulation;

- Privacy and Dignity;
- Continence – Bowel and Bladder Care;
- Safety of clients with Mental Health needs;
- Food and Nutrition;
- Personal and Oral Hygiene; and
- Pressure Ulcers.

Annual Audit Awards
The Trust's Annual Audit Awards were held in January 2011. This is open to any staff who have completed a clinical audit in the previous year and can demonstrate improvements as a result of their audit findings. The judges included a non-Executive Director, the Head of a GP Consortia, a Member's Councillor and a Medical Consultant. Ten entrants were short-listed to present their audits to a multidisciplinary audience. The winner was Dr Rebecca Duncombe with a presentation on 'Assessment and Management of Paediatric Pain'. As a result of this audit pain plans were introduced into Paediatrics, with a new drug chart that requires a pain score of administration of analgesics; a pain management group has been set up and additional education for staff in regard to analgesics and doses. The second placed audit was by Dr Nicola Fawcett entitled 'ANCA testing before and following introduction of local gating policy'. Education following this audit led to better use of this specialised test and improvements in both clinical and cost effectiveness.

Audits in Women's and Children's Services
During 2010-11 staff in Women's and Children's Services were involved in 90 clinical audits – further details can be found in Appendix 1. Examples of improvements made following audit include:

- In Maternity, an audit on the use of fibronectin in pregnant women resulted in reducing the length of stay, use of tocolysis, in-utero transfers and made financial savings. This improved the women's experience and the quality of the service provided.
- A drug chart audit was undertaken in Paediatrics to investigate drug errors. Real time feedback to individual staff when errors were noticed has helped to reduce medication related incidents. This has been complemented by multidisciplinary training and education.
- A patient satisfaction survey of women with cancer identified a need for a patient information leaflet. The women felt that the information given to them was fragmented and requested a leaflet with all relevant information in one place. A leaflet has now been developed.

Audits in Medicine and Emergency Care
During 2010-11staff in Medicine and Emergency Care were involved in 62 clinical audits – further details can be found in Appendix 1. Examples of improvements made following audit include:

- An audit of ANCA testing in 2009 has resulted in the introduction of a 'gating' system. The gating system ensures that clinicians discuss the test with the Immunology service prior to carrying it out. Re-audit has shown a reduction in testing.
- An audit of assessment of Delirium in the Acute Medical Setting has indicated the need for 10 questions in the clerking pro forma as prompts for assessment of delirium. The Abbreviated Mental Test Score has been added to the Clinical Decision Unit (CDU) clerking pro forma.
- Following audit of patients with acute pyelonephritis a policy on the management of pyleonephritis has been written and is now available on the Trust Intranet.

Audits in Surgical and Outpatient Services
During 2010-11staff in Surgical and Outpatient Services were involved in 66 clinical audits – further details can be found in Appendix 1. Examples of improvements made following audit include:

- CT scans to be carried out on a **selective** basis based on patients' clinical need to reduce the risks of radiation and to help save costs for breast patients.
- Development of an OPD patient information leaflet in relation to the services provided by the OPD and general patient information in relation to parking, what to expect at appointments etc.
- Inclusion of the VTE risk assessment into the new Trust drug charts. In line with NICE guidelines all adult patients must be risk assessed on admission regarding their risk of venous

thromboembolism. Adding the risk assessment to the drug chart will help prompt the medical for completion.
- Implementation of a pancreatitis clerking sheet in General Surgery to ensure that the correct information on patients' medical history are detailed, which will help with the right care provision.
- Nurse led discharge policy post laparoscopic surgery. This will make patients' discharge a smoother & more efficient process.

Audits in Core Clinical Services
During 2010-11 staff in the Core Clinical Services were involved in 112 clinical audits (55 completed and 57 still current) – further details can be found in Appendix 1. Examples of improvements made following audit include:
- A survey by Dietitians of weights and measurements of paediatric patients led to the creation of a nutrition working party to look at how this data was collected and plotted on growth charts, resulting in relevant paediatric staff receiving training and improved data collection on admission;
- In Imaging, an audit on the use of radiographic markers in the primary beam during x-ray improved quality of these examinations by introducing new markers and reminder slogans alongside an education programme;
- The Department of Critical Care carried out an audit on the timeliness of specialist consultant review of patients on the unit. A new patient daily review form was introduced for specialists to document their clinical opinions; and
- A Physiotherapy audit on obstetric anal sphincter injuries resulted in improved communication between maternity and physiotherapy for more efficient patient follow up.

Participation in Clinical Research
The number of patients receiving NHS services provided by Milton Keynes Hospital in 2010-11 that were recruited during that period to participate in research approved by a research ethics committee was 441.

Participation in clinical research demonstrates Milton Keynes Hospital's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

Milton Keynes Hospital was involved in conducting 67 clinical research studies during 2010-11, with a further 24 studies being followed up.

The improvement in patient health outcomes in Milton Keynes Hospital demonstrates that a commitment to clinical research leads to better treatments for patients. To give an example of our involvement in clinical research: the Trust took part in a randomised trial to establish the effectiveness of intermittent pneumatic compression to prevent post-stroke deep vein thrombosis (DVT). There is currently no guidance as to the use of stockings for stroke patients and NICE advise that stockings should not be used for DVT prophylaxis as previous trials showed they offered no clinical benefit. The new trial has shown that short stockings cause more DVT than long. A further trial is now being carried out to find out how effective intermittent pneumatic compression is in preventing DVT

There were 41 clinical staff participating in research approved by a research ethics committee at Milton Keynes Hospital during 2010-11, comprising Principal Investigators, research nurses and local collaborators. These staff participated in research covering twelve different medical specialties, including cancer, medicines for children, diabetes, stroke and Dementia and Neurodegenerative Diseases.

Our engagement with clinical research demonstrates Milton Keynes Hospital commitment to testing and offering the latest medical treatments and techniques.

Use of Commissioning for Quality and Innovation (CQUIN) Framework

A proportion of Milton Keynes Hospital NHS Foundation Trust's income in 2010-11 was conditional upon achieving quality improvement and innovation goals between Milton Keynes Hospital NHS Foundation Trust and any person with whom they entered into a contract agreement or arrangement for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

For 2010-11 the following CQUINs were agreed:

1. Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE).
2. Improve responsiveness to personal needs of patients.
3. Improve the outcomes and experiences of patients in hospital with heart failure (HF) by implementing the HF care bundle in line with the Advancing Quality methodology.
4. Improve the outcomes and experiences of patients admitted who have Acute Myocardial Infarction (AMI) by implementing the AMI care bundle in line with the Advancing Quality methodology.
5. Improve the outcomes and experiences of patients in hospital with Pneumonia (PN) by implementing the PN care bundle in line with the Advancing Quality methodology.
6. Improve the outcomes and experiences of patients admitted who have Hip and Knee Surgery (H&K) by implementing the H&K care bundle in line with the Advancing Quality methodology.
7. Maintain the low levels of grades 3 and 4 hospital acquired pressure ulcers achieved in 2009/10 throughout 2010-11.
8. Increase the normal birth rate and eliminate unnecessary Caesarean Sections.
9. All Stroke Patients will have a comprehensive stroke care plan and access to specialist staff.
10. All adults with diabetes will receive high-quality care throughout their admission, including support to optimize the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.
11. All patients admitted with an expected or actual length of stay of two nights or more to be screened using local nutritional screening tool. All of those requiring onward nutritional care plans have such plans documented for implementation in the community.
12. Milton Keynes Hospital NHS Foundation Trust will share data between the Emergency Department and the police regarding alcohol related crime and assaults in line with the data protection Act 1998.

2010-2011 Year End Performance Outcome

CQUIN Scheme	Possible Achievement	Actual Achievement
Venous Thromboembolism (VTE)	£207,227	Not achieved
Patient Experience	£207,227	£207,227
Heart Failure (Improving Quality Programme IQP)	£69,076	£69,076
Acute Myocardial Infarction (IQP)	£69,076	£69,076
Pneumonia (IQP)	£69,076	£69,076
Hip and Knee (IQP)	£69,076	£69,076
Pressure Ulcers	£207,227	Not achieved
Normal Births	£234,857	£234,857
Stroke	£234,857	£234,857
Diabetes	£234,857	Not achieved
Nutrition	£234,857	Not achieved
Emergency Department Data Sharing	£234,857	£176,143
TOTAL	£2,072,270	£1,011,959

Further details of the goals for 2011-12 are available on request and relate to the 'Key Priorities' for the Trust in 2011-12. Further details of the agreed goals for 2010-11 and for the following 12 month period are available online at:
http://www.monitornhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

Data Quality

Milton Keynes NHS Foundation Trust submitted records during 2010-11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS Number was:

- 99.5% for admitted patient care (national average was 98.4%)
- 99.8% of outpatient care (national average was 98.8%), and
- 98.1% for accident and emergency care (national average was 98.1%)

[Data as at month 10 inclusion date. Note: 100% is not expected because not all patients have NHS numbers].

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care (national average 99.8%);
- 100% for out patient care (national average 99.8%); and
- 100% for accident and emergency care (national average 99.7%).

Milton Keynes Hospital NHS Foundation Trust was not subject to Payment by Results clinical coding audit during 2010-11 by the Audit Commission.

The Trust's inpatient Health Care Resource Group (HRG) assignment error rate over the last three years, weighted to 2009-10 when the reported error rate was 3%, placed us amongst the top performing Trusts.

As a result the Trust did not receive a visit from the Audit Commission for the purposes of an inpatient clinical coding or outpatient audit during 2010-11. This was in line with their *Payment by Results Data Assurance Framework 2010-11 Programme* which set out their move to a more risk based approach. In 2010-11 audits were only carried out at poorly performing Trusts rather than their previous approach whereby every NHS Trust was audited.

Milton Keynes Hospital NHS Foundation Trust's Information Governance Assessment Report Score overall score for 2010-11 was 80% and was graded "green" for all categories except Corporate Records. An Action plan for Corporate Records has been prepared, which is being taken forward by the Trust Secretary. This Action Plan is being monitored by the Trust's Information Governance Steering Group.

More generally, the last annual data quality audit was completed in February 2011 for the year relating to 2010-11 in which a sample of pathways for 18 weeks and cancer services were included. An audit of 18 week and cancer services pathways will be undertaken as a routine part of the audit ongoing. Each audit is presented to the Trust's Care Standards Committee and the recommendations monitored as part of the Trust's IG audit plan (approved by the IG Steering Group).

Statement of Assurance from the Board

During 2010-11 Milton Keynes Hospital NHS Foundation Trust provided and/or subcontracted 37 NHS services.

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

The income generated by the NHS services reviewed in 2010-11 represents 100% of the total income generated from the provision of NHS services by Milton Keynes Hospital NHS Foundation Trust for 2010-11.

Quality Overview – How the Trust Monitors Quality

The Trust Board reviews a range of quality measures presented as a dashboard. Annual figures for these measures are detailed on the tables below.

Executive and non-Executive Directors participate in patient safety walk-rounds, visiting different areas of the hospital in order to have the opportunity to talk to frontline staff and patients, to see what improvements are being made or where further improvements are needed. The Matrons also carry out weekly walk-rounds in order to carry out checks of clinical areas in relation to patient safety and nursing care.

Within each directorate or department there is a Clinical Improvement Group with multi-disciplinary attendance and chaired by a Clinical Director. These groups review clinical governance within their area and provide action planning on topics including patient safety, risk management, incidents, policies and guidelines, patient information, clinical audit, complaints, learning and development, and quality assurance programmes. Reports from these groups are escalated to Board level committees in order to provide Directors with assurance that clinical governance is embedded in the Trust.

Trust Board Quality Measures:

This table covers two pages.

PATIENT SAFETY	Measurement used	Performance 2008-9	Performance 2009-10	Performance 2010-11
Hand hygiene compliance	Internal target – percentage compliance as measured by Matrons' Audits	69.1%	89.9%%	95.2%
Hospital-acquired pressure ulcers (grades 3 and 4)	Internal target – total number measured by Matrons' Audits	8	6	9 (grade 3 only)
Patient falls	Internal target – total number of reported incidents.	577	664	669
Medication incidents	Internal target – total number of reported incidents.	179	369	554*
Serious incidents	Internal target – total number of reported incidents.	37	35	44
'Never' events	This is a based on a nationally accepted list of events published by the National Patient Safety Agency.	0	0	0

CLINICAL EFFECTIVENESS	Measurement used	Performance 2008-9	Performance 2009-10	Performance 2010-11
Hospital standardised mortality ratio (HSMR): all	Risk of death relative to national average case mix adjusted from national data via Dr Foster Intelligence: this is a national definition. Target is below 100	88.5	83.4	92.9
Perinatal death rate	This data is provided by the Confidential Enquiry into Maternity and Child Health (CMACH), which is a national body	Perinatal 6.1 per 1,000 – as of 31.12.08	Perinatal 7.1 per 1,000 – Stillbirth 4.3 per 1,000 as of 31.12.09	Perinatal 6.1 per 1,000 – Stillbirth 4.3 per 1,000. Unconfirmed 2010 figure.
Readmissions under 14 days (elective)	Emergency admissions within 14 days of elective discharge, including day cases. Internally set target	Under 3.3%	5%	2.3%
Readmissions under 14 days (non-elective)	Emergency admissions within 14 days of non-elective discharge, including day cases. Internally set target	Under 9.5%	10.6%	10.0%
PATIENT EXPERIENCE	**Measurement used**	**Performance 2008-9**	**Performance 2009-10**	**Performance 2010-11**
Informal complaints from patients	The number of informal complaints from patients received by the Trust	264	136	343
Formal complaints	The number of formal (written) complaints from patients received by the Trust	304	354	300
Midwife : birth ratio	Birth Rate Plus Midwifery Workforce planning tool	1 to 40	1 to 30	1 to 30
WORKFORCE	**Measurement used**	**Performance 2008-9**	**Performance 2009-10**	**Performance 2010-11**
Staffing level incidents	Internal target – total number of reported incidents	1013	199	193
Incidents of violence towards staff	Internal target – total number of reported incidents	222	82	79

*The increase in number of Medication Incidents is due to the following factors:

- Zero tolerance to medication incidents in Paediatrics leading to more reporting.
- The introduction of NPSA alerts on missed doses, gentamicin prescribing in neonates, insulin prescribing, prescribing of low molecular weight heparins.
- The increase in the number of reports from medical staff following awareness training.

Performance against key national priorities and regulatory requirements 2008-11

Note: we have included performance in 2008-9 and 2009-10 to help demonstrate year-on-year variation. Certain indicators and targets have changed in the intervening time, which has been noted where possible.

This table covers two pages.

Indicator	Target and source (internal/regulatory /other)	Achievement 2008-9	Achievement 2009-10	Achievement 2010-11
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	>96% set by Monitor	Achieved	Achieved (98%)	Achieved (99.7%)
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	>85% set by Monitor	Achieved	Achieved (98%)	Achieved (92.3%)
Maximum wait of 2 weeks from GP referral to date first seen for all cancers	>93% set by Monitor	Achieved	Achieved (97%)	Achieved (97.5%)
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments	>98% set by Monitor	Not directly comparable to 2008-9 targets	Achieved (100%)	Achieved (100%)
Maximum waiting time of 31 days for subsequent cancer treatments: surgery	>94% set by Monitor	Not directly comparable to 2008-9 targets	Achieved (94%)	Achieved (100%)
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients	>93%	New target, introduced January 2010	Missed (92%)	Achieved (96.3%)
Referral to treatment within 18 weeks: - Admitted - Non-admitted - Specialty	Admitted: >90% Non-admitted: >95% Specialty: set by Monitor and Care Quality Commission; cannot under-achieve >3/18	Achieved	Admitted: achieved (92%) Non-admitted: achieved (95%) Specialty: 2/18 underachieved	Admitted: achieved (91.7%) Specialty: achieved 16/18 Non-admitted: Achieved (99.) Specialty: achieved 17/18
A&E treatment within 4 hours (including Walk-In Centre)	>95% Set by Monitor and Care Quality Commission	Achieved	Achieved (98.2%)	Achieved (96.4%)

Indicator	Target and source (internal/regulatory /other)	Achievement 2008-9	Achievement 2009-10	Achievement 2010-11
Thrombolysis – call to needle within 60 minutes	>68%	Missed (54%)	Trust number of cases (19) below de minimis level	Majority of patients transferred directly to Tertiary Centre for Primary Percutaneous Coronary Intervention (PCI)
Rapid Access Chest Pain Clinic % seen within 2 weeks	100% Set by Care Quality Commission	Achieved	Achieved (100%)	Achieved (100%)
Genito-urinary medicine clinics: % appointments available within 48 hours	100% set by Care Quality Commission	Achieved	Achieved (100%)	Achieved (100%)
Cancelled operations: %age readmitted within 28 days	>95%	Achieved	Achieved (100%)	Achieved (99%)
Clostridium Difficile infections in the Trust	81 set by Monitor	Achieved	Achieved (31)	Achieved (33)
MRSA bacteraemia (in Trust)	6 set by Monitor		Achieved (1)	Achieved (1)
MRSA bacteraemia (across Milton Keynes total health economy)	9 set internally		Achieved (2)	Achieved (2)

Regulatory requirements

Care Quality Commission (CQC)

The Care Quality Commission's (CQC) new regulatory regime came into force on 1st April 2010, and the Trust was registered with one restrictive condition and twelve compliance conditions. The restrictive condition required the Trust to ensure that all women in established labour receive one-to-one care from a registered midwife.

The Trust developed a Compliance Plan to ensure that it delivered all of the necessary actions to meet the CQC's registration conditions by the specified deadlines.

New governance and committee structures were agreed by the Trust Board with phase one at sub-board level agreed in April 2010 and phase two at operational level agreed in May 2010; this committee and group structure was designed to ensure that important information and decision-making could be more easily escalated from the frontline of care to Trust Board and back again. This mechanism has provided a greater opportunity for all staff to share from lessons learnt through the investigations and actions taken when patient safety or care has been compromised.

The hard work and dedication of staff in all areas of the hospital to take actions to remove these compliance conditions were realised when in September the CQC agreed to lift nine of the twelve conditions. The Trust continues to work hard to ensure the final removal of compliance conditions as

this will recognize improved standards of care in the hospital's maternity unit and high satisfaction ratings from local mothers.

However, following an unannounced visit in January, the CQC identified some areas for improvement in the hospital around respect and involving patients, infection prevention and control and record-keeping. Since that visit, the Trust has put together an action plan and has been working hard to ensure that in these important areas the hospital is delivering the standard of care that patients expect.

Day-to-day business with the new CQC Regulations and Outcomes
The Trust has in place a schedule for assessing compliance with the Care Quality Commission's Standards for Health and Social Care on an ongoing basis. The Trust has Provider Compliance Assessment Templates complete for all 16 regulations and associated outcomes. The Trust works hard to address areas of concern identified by its own internal mechanisms for evaluating compliance and this work is monitored via a new Compliance Committee which was introduced in June 2010.

Monitor

We currently have a red governance rating from Monitor, the Foundation Trust regulator having been found (on 2 March 2010) in significant breach of condition 5 of our terms of authorisation, namely the requirement to ensure the existence of appropriate arrangements to provide representative and comprehensive governance to maintain the organisational capacity necessary to deliver the mandatory goods and services set out in Schedule 2 of its authorisation.

As a consequence, Monitor used its formal powers under Section 52 of the NHS Act 2006 to require the Trust to appoint external expert clinical advisors, to assist the Trust to accelerate the delivery of necessary improvements within maternity services and wider governance issues. Between April and June, PricewaterhouseCoopers (PwC) were brought in to advise the Trust on improvements to governance, Board arrangements and project and risk management approaches.

In response to PwC reports a Governance Plan was produced in order to systematically address the issues raised, and a further review by PwC reported in November that we had in place all the necessary processes. The Governance Plan project is being formally closed down at the Portfolio Board on 13 April 2011 with just 4 (of an original 152) actions to be dealt with.

PART THREE – Review of Quality Performance

How we performed on our improvement priorities from last year (2010-11)

1. To improve the quality of maternity services

During 2010-11 we have continued to focus on improving our maternity services achieving completion and significant progress on our priorities for last year.

In September 2010 the Care Quality Commission and Monitor lifted nine of the twelve conditions from the hospital's registration regulations following the regulatory action taken against the Trust, in March 2010, imposing a further schedule of Compliance Conditions and a Restrictive Condition.

From 1st April 2010, further to the Restrictive condition, systems and processes were put in place to ensure and demonstrate that one-to-one care for all women in established labour is maintained at all times. We believe this is central to providing safe care for women and babies and that it is essential that we continue to demonstrate our commitment to provide one-to-one care year on year.

A key priority during 2010-11 was the ongoing recruitment of midwives to achieve a midwife to birth ratio of 1:30, and over the past eighteen months, the Trust has been implementing a robust recruitment campaign at both a local and national level to increase the number of substantive midwives employed to meet patient demand and the delivery of one-to-one care for all women in established labour.

Proactive recruitment continues to be ongoing via a rolling national advertising campaign which has reduced the midwifery vacancy factor to an overall reduction of 13% in the vacancy factor since April 2010. As of April 2011 there will be 119.0 whole time equivalent (WTE) midwives in post leaving an outstanding vacancy factor of 3.0 WTE against the current funded establishment.

Staff turnover for midwives is currently running at 5.4% (year to date) which is a 2.4% reduction on the year end figures for 2009-10. Human Resource department analysis of exit interviews suggests that the key reasons identified by staff leaving posts are retirement, career progression and family relocation rather than dissatisfaction with the organisation

In addition key leadership posts have also been appointed to and these included a Consultant Midwife, Maternity Governance and Risk Lead and Deputy Head of Midwifery. Alongside this a ninth Consultant in Obstetrics and Gynaecology has been appointed and we are achieving 60 hour consultant cover on labour ward. These roles have improved leadership presence and support for clinical decision making, team building and education in the work environment.

Quality improvement and patient safety in maternity services continues to underpin practice through our strengthened management structure and processes to embed governance. This is evidenced in achieving Clinical Negligence Scheme for Trust (CNST) level I compliance; 100% attainment of mandatory training for midwives and the introduction of PROMPT training (Practical Obstetric Multi Professional Training); shared learning and changes in practice in response to serious incidents and complaints which represent less than 1% of the total number of births.

The 'normalising birth' agenda is another and remains an ongoing priority for us in delivery of quality care. Progress in this respect is demonstrated in the increase normal birth rate of 63% and decrease in caesarean section rate to 24%.This work is being led by the consultant midwife and being achieved through:

- the development of a normal birth strategy and strengthening of the normal birth pathway;
- established Vaginal Birth After Caesarean (VBAC) clinics;
- the implementation of the of the caesarean section toolkit in collaboration with the National Institute for Innovation;

- the establishment of weekly multidisciplinary team caesarean section review meetings;
- improved midwifery staffing levels and provision of one-to-one care in labour.

Patient, Public and Staff Engagement has been integral to our progress and to enable continuous improvement and development of maternity services in line with patient need.

We worked closely with Milton Keyes Council Maternity Monitoring Panel who concluded and reported back to the Health and Well-Being Select Committee that the maternity unit was performing well in respect of the quality of patient and staff experience and that improved governance arrangements have been established to secure the maintenance and continuing improvement of performance.

Internal patient exit surveys and Care and Support in Labour surveys have reported high levels of patient satisfaction with an average satisfaction score of 95%. To broaden patient public involvement a patient panel chaired by the members' council has been established as a quarterly forum.

We have improved engagement with staff through staff surveys, workshops and agreed action plans whereby staff voices and views are heard and lead to sustained improvement and satisfaction in their work and so help provide better care for patients. The survey showed some tangible evidence of areas for improvement however it also identified that staff felt supported in training and development and overall felt more confident than a year ago.

The Trust has also invested significantly in a comprehensive maternity refurbishment programme, which is currently underway and due for completion by the summer 2011 which will provide a better birthing and work environment in response to staff and patient consultation.

The Trust produces data on clinical risk in maternity services to inform its understanding of morbidity factors and ensure that any issues are identified quickly and appropriate action taken in response.

Measures of achievement 2010-11 were monitored through the Trust's own maternity dashboard, and were compliant with requirements of:

- % increase in Normal birth rate >60%
- % decrease in caesarean section rate <25%
- % smoking cessation: Mothers smoking at delivery <13%
- % uptake of breast feeding: >75%
- % booking before 13 completed weeks >86%
- Peri-natal and Stillbirth rates within national confidence rates
- Patient Satisfaction Surveys
- Governance standards compliance

2. To further reduce healthcare-associated infection rates

The Trust achieved considerable success in this regard in 2010-11. We remained below trajectory for both MRSA bacteraemia (blood stream infection) at 1 case during the reporting period and 33 cases of Clostridium Difficile. (The maximum permitted was 4 cases of MRSA and 56 of C Diff).

The investigation into cases of MRSA bacteraemia and Clostridium difficile benefits from a shared approach between us and the local community infection prevention team. Information on patients with a positive result for Clostridium difficile and or MRSA status being admitted to the hospital or discharged home is pooled between the two teams. All patients deemed at high-risk (people who need through-the-skin medical devices like long lines or devices such as urinary catheters) are monitored continuously by us and, where indicated, the GP is alerted as is the community infection prevention and control nursing team to minimise the potential for further complication to occur.

Adherence to the antibiotic policy remains under constant scrutiny, with alert stickers placed on patient medication charts by the ward based pharmacist to remind the medical teams to review the

choice of antibiotic, the route of administration and the number of days to be prescribed. An altered focus has been adopted for specific groups of older, more vulnerable adults by further restricting the use of certain antibiotics and by introducing a probiotic drink to the diet in an attempt to encourage a healthy gut flora. A dedicated multidisciplinary team has been brought together to monitor the preventative measures for C Diff. This group is made up of the Chief Nurse, the Medical Director, the Associate Medical Director both Consultant Microbiologists, the infection prevention nurse team, a dietician and a gastroenterologist.

From April 2010, adult patients requiring a urinary catheter were offered the nitrofuranzoin (NF) coated urinary catheter in support of reducing the potential to have a catheter associated urinary tract infection (CAUTI) which accounts for a large percentage of infections in acute and community settings.

This initiative joins the Red Jug and Mug project (which was referenced in the NHS Institute and Nursing and Midwifery Council's *High Impact Actions For Nursing And Midwifery* document) to reduce dehydration and length of hospital stay. If this continues to show results, we would expect to see a further reduction in patients being assessed as needing a urinary catheter in future.

3. To improve the experience of patients using the hospital

A more extensive range of pressure relieving equipment and the introduction across the Trust of electric profiling beds has had a positive impact in improving patient care and the hospital environment. Beds for bariatric patients are also available and have increased the quality of care for these patients. The Trust also purchased patient bedside chairs with pressure relieving cushions integral to the chair ensuring a 24 hour concept of pressure relief.

The Trust also participates in regular robust audits monitoring the incidences and prevalence of pressure ulcers. There have been nine Grade 3 hospital acquired pressure ulcers during 2010-11 this is against an increased population of over 65 years age and high risk reduced mobility patients. These are reported as Serious Incidents and result in a comprehensive root cause analysis investigation with nursing and medical staff involved to ensure that the Trust shares the learning outcomes by cascading best practice in pressure ulcer prevention treatment and management. This ultimately improves the patient's experience and reduces unnecessary harm to patients.

The annual Patient Environment Action Team (PEAT) Audit was undertaken in March 2011; the team includes hospital staff, an independent team member from a neighbouring Trust and three Members' Council Governors. The emphasis of the audit is to view the Trust from the patient's perspective. The team assessed the general condition of the environment focussing on issues such as general décor, floors, cleanliness, odour, lighting, signage, patient equipment and accessibility. On completion of the audit the PEAT Team was satisfied that the hospital is maintained to a good standard of hygiene and cleanliness. It allowed for the identification of some areas that need improvement and for comparisons to be made between different areas that will ensure the ongoing provision of a good standard of health service for the local community. Results from the audit are fed into a national database and feedback will be available in May/June 2011 following evaluation and results will be advertised on the Patient Safety Agency website.

We have had zero 'never' events (so-called because they are ones that should never happen, such as surgery on the wrong limb or organ) in the Trust over the past year.

Who we have involved to develop our Quality Account for 2011-12

The development of the Quality Account has been led by the Chief Operating Officer/Director of Nursing and the Head of Clinical Governance, and co-ordinated by the Clinical Governance department. It has also involved:

- Our Patients, their families and friends via feedback nationally and locally through surveys, complaints and compliments;

- Our Staff, via national and local surveys, reporting of incidents, the investigation of these and outcomes for shared learning;
- Our internal Governance Boards, Committees and Groups (which include Medical and Nursing staff and Allied Health Professionals) who have analysed this information and made decisions for quality improvement initiatives where required;
- Our commissioners NHS:Milton Keynes who we work with to develop our Quality Schedule which forms part of our Provider Contract; and
- Organisations in the community who advocate for patients who may use our services.

This report has been compiled using information supplied by the following:

- Chief Executive;
- Medical Director;
- Chief Operating Officer/Chief Nurse;
- Head of Clinical Governance
- Head of Nursing;
- Trust Secretary;
- Deputy Director of Infection Prevention and Control;
- General Manager Women's & Children's Services;
- General Manager Surgery;
- Chief Pharmacist;
- Head of Midwifery;
- Head of Patients Services;
- Head of Research and Development;
- Head of Contracts;
- Head of Information Management and Technology;
- Cancer Services Manager;
- Information Manager;
- Patient Experience Manager;
- Health & Safety Manager;
- Datix (incident reporting system) Manager;
- Advanced Nurse Tissue Viability;
- Patient Safety Lead (Surgical & Outpatient Services) and
- Clinical Governance Facilitators.

The draft report was reviewed by the following multi-disciplinary committees in Milton Keynes Hospital NHS Foundation Trust:

- Care Standards Committee – 20th April 2011.
- Strategic Planning and Policy Committee – 4th May 2011.
- Council of Governors – 12th April 2011.
- Patient, Public and Staff Experience Committee – 8th April 2011.
- Quality Committee – 19th April 2011.
- Management Board – 26th April 2011.
- Trust Board – 1st circulation 19th April 2011 Final Approval 1st June 2011.

The report was also sent for comment to:

- GP Consortia – 11th May 2011.
- NHS:Milton Keynes – 11th May 2011.
- Link:MK – Presentation via Patient, Public and Staff Experience Committee (as above) and formal circulation 19th April 2011.
- Milton Keynes Council Health and Community Select Committee – Presentation 14th March 2011 and formal circulation 19th April 2011.

Statements provided by Commissioner, LINks and local Council

Statements provided by NHS:Milton Keynes (our commissioner) and LINks:MK can be found in full in the Annex to this document. The document was also shared with Milton Keynes Council Health and Community Wellbeing Select Committee, however due to the intervention of the local elections in May 2011 no response has been received.

Feedback on the Quality Accounts

Milton Keynes Hospital NHS Foundation Trust would welcome feedback on this report from members of the public. We would like to know what you think of this report, and what you would like to see included in next year's report.

If you wish to comment please contact us by writing to:

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Milton Keynes Hospital NHS Foundation Trust
Standing Way
Eaglestone
Milton Keynes
MK6 5LD

Or by email to: kay.taft@mkhospital.nhs.uk

Or by telephone on: 01908 243420

Appendix 1: Participation in Clinical Audit

National Audit Programme
During 2010-11 the National Clinical Audit and Patient Outcomes Programme contained the following audits. The Trust's participation is reflected in the table below (table covers two pages):

Audit	Participation	% Cases submitted
Cancer		
Bowel Cancer (NBOCAP)	Yes	Data to be made available in future
Head & Neck Cancer (DAHNO)	Yes	Data to be made available in future
National Lung Cancer Audit (NLCA)	Yes	Data to be made available in future
Oesophago-Gastric Cancer	Yes	Data to be made available in future
Mastectomy and Breast Reconstruction	Yes	Data to be made available in future
Women & Children		
National Neonatal Audit (NNAP)	Yes	Report from NNAP not received as yet
Paediatric Intensive Care Audit Network (PICANet)	Specialist service not provided by the Trust	Not applicable
Heavy Menstrual Bleeding	Yes – commenced February 2011	39 cases submitted so far (100% who presented)
Childhood Epilepsy	No – Trust will participate in 2011-12 (commencing May)	Not applicable
National Diabetes Audit Paediatrics	Yes	100% who presented
Heart		
Adult Cardiac Surgery	No	
Congenital Heart Disease (including paediatric surgery)	Specialist service not provided by the Trust	Not applicable
Coronary Interventions	Specialist service not provided by the Trust	Not applicable
Myocardial Ischaemia (MINAP)	Specialist service not provided by the Trust	Not applicable
Cardiac Ambulance Services	Specialist service not provided by the Trust	Not applicable
Heart Rhythm Management	Yes	TBC
Heart Failure	Yes	100% of patients admitted through Cardiology Team
Long-term conditions		
Diabetes	Yes	100% of patients within the hospital on the day of the audit
Renal Services *(vascular access; patient transport)*	Specialist service not provided by the Trust	n/a
National Joint Registry (NJR)	Yes	447 cases
Inflammatory Bowel Disease	Yes	Audit in progress
Pain Database	No	
Food and Nutrition Audit	No	

Mental Health		
Dementia	Not completed due to lack of resources. Action plan in placed based on national data.	Not applicable
Psychological Therapies	Specialist service not provided by the Trust	Not applicable
The National Audit of Schizophrenia (NAS)	Specialist service not provided by the Trust	Not applicable
Older People		
The Sentinel Stroke Audit	Yes	100%
Carotid Interventions Audit	No	
Falls and Bone Health Audit	Yes	Data to be made available in future
Continence Care Audit	Yes	Data to be made available in future
Hip Fracture Database	Yes	Data to be made available in future

The reports of relevant national clinical audits and local audits have been reviewed by the relevant departments and reported via governance arrangements.

Audits in Women's and Children's Services

During 2010-11 staff in the Women and Children's Services were involved in 90 clinical audits:

Specialty	Current Audits	Completed audits	National audits	Postponed	Cancelled	Total
Paediatrics & Neonatal Unit	12	16	4	0	1	33
Maternity	14	20	2	0	1	37
Gynaecology	3	8	1	2	0	14
Sexual Health	3	3	0	0	0	6
Grand Total	32	47	7	2	2	90

Each audit may be triggered by a number of reasons; these are outlined in the table below.

Specialty	Paediatrics & Neonatal Unit	Maternity	Gynaecology	Sexual Health
Incident	6.0%	2.7%	7.2%	16.7%
Local Policy	24.3%	19.0%	14.2%	50.0%
National Audit	12.1%	5.4%	7.2%	0.0%
National Policy	18.2%	2.7%	0.0%	0.0%
Safety Alert	0.0%	0.0%	0.0%	0.0%
Service Development	39.4%	70.2%	71.4%	33.3%
Total	100.0%	100.0%	100.0%	100.0%

Audits in Medicine and Emergency Care

During 2010-11staff in Medicine and Emergency Care were involved in 62 clinical audits:

Specialty	Current Audits in progress	Ongoing Audits	Completed	Total
Emergency Dept	3	2	7	12
Cancer Services	6	0	1	7
Respiratory	5	1	0	6
Cardiology	7	3	4	14
Diabetes	1	1	1	3
Endoscopy/GI	3	0	2	5
Neurology	4	1	2	6
Other	6	0	3	9
Total	35	8	20	62

Each audit may be triggered by a number of reasons; these are outlined in the table below.

Trigger	Emergency Dept	Cancer Services	Respiratory	Cardiology	Diabetes	Endoscopy /GI	Neurology	Other
Incident	8.3%	0.0%	16.7%	16.7%	0.0%	0.0%	33.3%	22.2%
Local Policy	25.0%	16.7%	16.7%	16.7%	33.3%	0.0%	0.0%	55.6%
National Audit must	33.3%	16.7%	50.0%	41.7%	33.3%	40.0%	16.7%	0.0%
National audit optional	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
National Policy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Safety Alert	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	0.0%
Service Development	33.3%	66.7%	16.7%	25.0%	33.3%	40.0%	50.0%	22.2%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Audits in Surgical and Outpatient Services

During 2010-11staff in Surgical and Outpatient Services were involved in 66 clinical audits:

Specialty	Current Audits	Completed audits	Lack of information	Total
T&O	3	9	3	15
General Surgery	8	24	0	32
H&N	2	8	5	15
Theatres	2	2		4
Total	15	43	8	66

Each audit may be triggered by a number of reasons; these are outlined in the table below.

Trigger	T&O	General Surgery	H&N	Theatres
Incident	27%	9%	6.3%	25%
Local Policy	20%	18%	6.3%	25%
National Audit must	13.3%	9%	12.5%	0
National audit optional	0	3%	0	0
National Policy	13.3%	9%	0	0
Safety Alert	0	0	0	25%
Service Development	13.3%	34%	37.5%	25%
Other	13.3%	18%	37.5%	0
Total	100.0%	100.0%	100.0%	100.0%

Audits in Core Clinical Services

During 2010-11 staff in Core Clinical Services were involved in 112 clinical audits (55 completed and 57 still current) – breakdown by Specialty is shown in the table below:

Specialty	Current Audits	Completed audits	Total
Anaesthetics	8	5	13
Dietetics	6	8	14
DoCC	4	12	16
Imaging	2	1	3
Pathology	6	4	10
Pharmacy	9	14	23
Physiotherapy	17	16	33
Total	52	60	112

Each audit may be triggered by a number of reasons; these are outlined in the table below.

Trigger	Anaesthetics	Dietetics	DoCC	Imaging	Pathology	Pharmacy	Physio-therapy
Incident	15.4%	0.0%	20.0%	33.3%	0.0%	0.0%	2.9%
Local Policy	7.7%	50.0%	0.0%	0.0%	22.2%	58.3%	23.5%
National Audit	7.7%	8.3%	40.0%	0.0%	22.2%	4.2%	2.9%
National Policy	7.7%	16.7%	6.7%	0.0%	22.2%	16.7%	0.0%
Safety Alert	0.0%	0.0%	0.0%	0.0%	11.1%	16.7%	0.0%
Service Development	61.5%	25.0%	33.3%	66.7%	22.2%	4.2%	70.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

ANNEX A – Statements from NHS:Milton Keynes, Milton Keynes LINk and Milton Keynes Council's Health and Community Select Committee

Milton Keynes Hospital NHS Foundation Trust Quality Accounts And Report 2010-11 – NHS:Milton Keynes Response

NHS Milton Keynes has reviewed the draft Milton Keynes Hospital NHS Foundation Trust's (MKFT) Quality Account 2010/11. All of the nationally mandated elements of a Quality Account are covered and there is evidence that MKFT has used both internal and external assurance mechanisms.

NHS Milton Keynes has discussed the accuracy of the data contained in the Quality Account and has been assured that this reflects current known and validated information.

NHS Milton Keynes acknowledges that 2010/11 has been another challenging year for MKFT. We recognise that working with Monitor and the Care Quality Commission (CQC), as well as South Central Strategic Health Authority and ourselves, MKFT is striving to provide the best possible clinical care and safety to patients. NHS Milton Keynes will continue to work closely with MKFT and support their ambition to achieve excellence in the quality of care provided to patients, through quality monitoring, incentivising (through CQUIN Schemes), and performance management.

NHS Milton Keynes are pleased to note that MKFT have fully achieved 6 and partially achieved two out of a possible twelve CQUIN schemes this year and that the Quality Account identifies significant progress in relation to:

1. Low rates of MRSA/CDifficile; and
2. Improvements in Maternity Care.

It is disappointing to note that 4 CQUIN schemes were not achieved as all of these would have made a significant difference to patients. These were:

1. Reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE);
2. Reduction in the number of patients with preventable pressure ulcers;
3. Implementation of the "Think Glucose" project to ensure that adults with diabetes receive high quality care throughout their admission, including support to optimize the control of their blood glucose, blood pressure and other risk factors for developing complications of diabetes;
4. All patients admitted with an expected or actual length of stay of two nights or more will be screened using a local nutritional screening tool.

MKFT have identified areas for improvement linked to patient experience:

1. Enhance the quality of life for people with long-term conditions and help people to recover from episodes of ill health or injury;
2. Further improve the quality of maternity services; and
3. Treating and caring for people in a safe environment and protecting them from avoidable harm.

NHS Milton Keynes recognises that quality improvement requires a culture shift and collaborative effort by all staff from ward to Board. We have first hand experience and knowledge of your staff's dedication and hard work in many areas of MKFT activity. NHS:Milton Keynes also expects that the MKFT Board will lead the necessary improvements, and ensure that there is effective medical leadership necessary to secure and sustain improvements in patient experience and quality of services.

We believe that this coming year will be challenging both clinically and financially. We are sure that the MKFT Board is determined to equip themselves with the resources required to address these challenges to improve services for local people.

Milton Keynes Hospital NHS Foundation Trust Quality Accounts And Report 2010-11 – LINk:MK Response

LINk:MK welcomes the opportunity to register our comments on the Milton Keynes Hospital Quality Accounts for 2010/11.

We would like to acknowledge and commend on the significant improvements made in the provision of Maternity Services in the past year and the lifting of the remaining conditions imposed by the Care Quality Commission. Also, we are pleased to note that the Trust has continued to maintain its achievements from last year with regard to the reduction in healthcare associated infection rates.

We are also pleased to see that listening to patients experiences, improving communication and identifying what is of value to the patient is a priority for 2011/12. LINk:MK provides an independent means in enabling everyone in the community to share their views, experiences and receives comments and feedback on local health and social care services. It is in this context that LINk:MK looks forward to working with the Trust in the coming year and in particular the improvement in access to services for the Hearing and Visually impaired within the Hospital, which is an area of concern to LINk:MK. We also look forward to the continuance of the Patient Public and Staff Experience Committee and hope to see some significant improvements in the current year.

We believe that by giving people the confidence to say what they want from services and the ability to be involved, ultimately results in a better system. We also recognise the commitment of the Trust to deliver good quality healthcare services to the community and we assure our support in working together, to make service improvements that benefits the citizens of our community and is ever more responsive to their needs.

27th May 2011

Milton Keynes Hospital NHS Foundation Trust Quality Accounts and Report 2010-11 – Health and Community Wellbeing Select Committee, Milton Keynes Council Response

The Quality Account was submitted to the Health and Community Wellbeing Select Committee for comment. However, due to the local elections held in May 2011, the committee was unable to re-form and review this document by the required deadline in June 2011. Update if received.

ANNEX B – 2010-11 Statement of Directors' Responsibilities in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporates the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual*;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011;
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011;
  - Feedback from the Commissioners dated 23rd May 2011;
  - Feedback from the governors (none received) final report to be circulated 23rd May 2011;
  - Feedback from LINks dated 27th May 2011;
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, included in the Trust's Annual Report;
  - The 2010 national patient survey January 2011;
  - The 2010 national staff survey March 2011;
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 15th April 2011;
  - Care Quality Commission quality and risk profiles dated March 2011;
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB sign and date in any colour ink except black

..... Date ..... Chairman

..... Date ..... Chief Executive