ITEM 4(iii)

QUALITY ACCOUNTS PANEL

31 MAY 2012

Milton Keynes Hospital NHS
NHS Foundation Trust

Milton Keynes Hospital NHS Foundation Trust

Quality Accounts and Report 2011-12

4th Draft for Consultation
Updating information to include Quarter 4

Working Draft Number: 4

Key to text colours and highlights:

Yellow highlighted text = these are the required statements in the account which must be made in form as per the set template.

Pink highlighted text = items to be included as per toolkit guidance (wording flexible)

Red Text is where further information is required.

Part One - A Statement on Quality from the Chief Executive

Introduction
Welcome to our third Quality Account for Milton Keynes Hospital NHS Foundation Trust. This publication describes just how seriously we consider quality and safety issues in our hospital and how we work continuously to make the right improvements. We want both our patients and visitors to feel confident of the quality of our services, and this Quality Account sets out our priorities for improvement and details how we have performed against some key quality measures over last year.

What is a Quality Account?
Quality Accounts are annual reports about the quality of services that providers of healthcare deliver and their plans for improvement. The purpose of Quality Accounts 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;
- Boards of NHS providers to report on the improvements made to their services and set out their priorities for the following year.

There are three important quality improvement areas. These are:

- Safety;
- Patient Experience; and
- Clinical Effectiveness.

We have included our full Quality Account here as part of our Annual Report, which contains information about the quality of our services, the improvements we have made during 2010/11 and sets out our key priorities for next year (2012-2013). This report also includes feedback from our patients, governors and commissioners on how well they think we are doing.

In Part One, of this report we reflect on what we have achieved this past year and how well we have met the goals we aspired to in our last quality report and in Part Three we look forward to next year with our new aims for improvement in the Trust.

What are the Trust's Commitments to Quality?
Milton Keynes Hospital NHS Foundation Trust is dedicated to delivering a quality service to our population. In 2012, the Trust agreed a Quality Assurance Framework which outlines the processes and systems in place to ensure patients receive excellent quality care which is safe.

The Trust is committed to:

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

"The friendly, patient and helpful staff in this Ward are highly motivated and focused on giving the best possible treatment to all in their care. You are assured of the best level of care and a speedy recovery." (NHS Choices, Sept 2011)

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.

During 2011- 2012, the Trust has worked hard and will continue to do so to ensure the ongoing improvement of 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;
- ensure that we spot quickly when things do not go well; and that
- we learn the lessons to prevent repetition of adverse events.

In January 2012, the Trust's Board of Directors undertook a self-assessment against Monitor's Quality Governance Framework; this process helped the Trust to identify areas where further improvements could be made and as a result of this, the Trust introduced in January 2012 a new Quality, Performance and Safety Board of Directors Report with an aim to ensuring focused and refined information could be presented together to inform decision making at Board Level.

Financial situation and Year One of Transformation Programme

To address the financial challenges facing the health economy in Milton Keynes we launched the Transformation Programme in January 2011. The savings target is £27.7million over two years. During the first year of the programme Milton Keynes Hospital NHS Foundation Trust saved £10.7million. Its focus is on changing the way services are delivered, improving quality and making them more efficient. Our operational performance has already seen significant improvement, thanks to renewed focus on quality. There are 24 Transformation projects.
Key projects are around theatres efficiency, pharmacy and pathology efficiency and length of stay. Our focus:

- providing the quality care our patients deserve;
- changing the way we work and saving money to be a sustainable organisation; and
- being as good as the best and the first choice for local patients and General Practitioners (GPs).

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 be inserted once approved

Mark Millar
Interim Chief Executive
1st June 2012

Part Two – Our priorities for Improvement for 2012/13

How our priorities were chosen
In drawing up our priorities for improvement for 2012/13 we have taken into consideration our progress against last year's priorities some of which are now secured as business as usual whilst others required continued focus.

We have also considered the local, regional and national picture, our overall performance as well as the views of patients, our staff, our Council of Governors, Commissioners (NHS: Milton Keynes, patient representatives from our local LINk, Health and Community Wellbeing Select Committee and our Patient, Public and Staff Experience Committee.

Following a process of engagement, which included review of concerns raised through incidents or complaints as well as engaging with patients via local and National surveys, and local forums we have agreed our key priorities for this coming year which we believe should be our focus in improving patient experience, safety and clinical effectiveness. These priorities have been endorsed by the Trust's Board of Directors.*To be agreed.

Clinical Effectiveness

Enhancing quality of life for people with long-term conditions and helping people to recover from episodes of ill health or injury.

Priority 1a: We will strengthen safeguarding arrangements for those in our care.

Why have we chosen this priority?
We want to make sure that patients who come to Milton Keynes Hospital have the best possible care and clinical outcomes to ensure their quality of life is improved.

How will we achieve this?
We will continue to develop our work around staff awareness and training specifically to ensure that patients are identified and receive care in the most appropriate place dependant on their needs and we will introduce additional stretches within our existing targets to ensure continuous growth and improvement within the service we provide to these patients. As our patient population becomes increasingly elderly and vulnerable we want to ensure that our nursing care meets their needs and promotes well-being.

Specifically we plan to:-

- Provide additional and focused staff training to improve competency around mental capacity assessments and appropriate referral to specialist care;
- Set targets for staff training; and
- Measure patient, relative, carer experiences.

How will we measure our improvement?

- Assess the quality of care provided via internal inspections;
- Measure patient, relative and carer experience via internal and external surveys.

What will our target be?
To ensure that all vulnerable patients are identified and their needs assessed to ensure they are enabled and empowered to access the care they need.

Priority 1b: We will improve the effectiveness and efficiency of the care we provide.

Why have we chosen this priority?
Over the past year the Trust have introduced lots of new ways of doing things to refine processes to ensure patients get effective and efficient care; we know there is more that can be done. We will continue to review and refine a selection of key care pathways. **To be agreed.

How will we achieve this?
Review of care pathways against evidence best practice and refine where required.

How will we measure our improvement?
By measuring the patients experience in terms of clinical effectiveness and patient outcomes.
What will our target be?

To have reviewed and improved four care pathways across the year.

Patient Safety

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

Draft Priority 2a: We will ensure that patients receive high quality and safe care from well trained staff.

Why have we chosen this priority?
The Trust has worked hard to benchmark compliance with mandatory training during 2011/12; it needs to focus further on improving compliance with Trust policy in this area to ensure continued progress in this area.

How will we achieve this?

- Ensure all staff have an annual appraisal, a professional development plan and have completed all their mandatory training requirements.

How will we measure our improvement?

- By benchmarking mandatory and local training records to ensure compliance with Trust policy;
- By setting stretch targets for areas where improvement in compliance is required.

What will our target be?

- Benchmark performance at the end of Quarter 1; and
- Set stretch targets Quarterly for the remainder of the financial year.

Patient Experience

Ensuring people have a positive experience of care.

Draft Priority 3a: We will improve our communication with patients and the public.

Why have we chosen this priority?
Our National and Internal Inpatient and Outpatient survey results, along with information around complaints and incidents tell us that good communication is key to ensuring that staff provide and patients receive high quality and safe care.

How will we achieve this?
Specifically we plan to:

- Using our National and Internal Survey results, benchmark perceptions and set targets to improve communication between staff to staff and staff with patients to improve the patient experience;

How will we measure our improvement?

- The Trust will introduce the Net Promoter Score into its internal survey and set internal targets for improvement.
- We will use the results of our internal and National Survey results to ensure that improvement is made; and
- We will also use our internal information on compliments, complaints and incidents occurring to assess prevalence and improvement within key areas.

How will we monitor and report our improvement?
Improvement will be monitored via the following mechanisms:

- At service level via review of Clinical Service Unit (CSU) Performance Dashboard;
- At the Management Board via Quality, Safety and Performance Reporting; and
- Quarterly CSU Performance Assessment Review with the Executive Team.

Reporting will be made:

- At service level to the CSU Clinical Governance/Improvement Group (monthly);
- At Trust wide level to the Management Board (Quarterly);
- At Board level via the Quality, Safety and Performance Reporting at the monthly Board of Directors meeting (monthly); and
- At to the Quality Committee (Quarterly).

Part Three – Our priorities for 2011/12

We want to ensure the highest possible standards of quality for our patients, meeting and exceeding their expectations in terms of patient experience, safety and clinical effectiveness. Each year we set ourselves key priorities under each of these headings which help us to focus on those areas most in need of our attention and continued vigilance.

In this section, we describe our achievements against each of the key priorities we set ourselves last year and our plans for further improvement this year.

Review of our key priorities for 2011/12

Last year we set ourselves four priorities under the following headings; these priorities had specific work-streams attached to them which linked to our Quality and CQUIN Schedule for 2011/12:

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.

Patient Safety

2. To continue to improve the quality of maternity services.

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

Patient Experience

4. Ensuring people have a positive experience of care.

Clinical Effectiveness

Priority 1: Enhancing the quality of life for people with long-term conditions and helping people to recover from episodes of ill-health or injury.

Why was this a priority?
We want to make sure that patients who come to Milton Keynes Hospital have the best possible care and clinical outcomes to ensure their quality of life is improved.

What did we do in 2011/12?
End of Life Care
Over the past few years, a major drive has been underway to ensure that people nearing the end of their lives and their relatives and carers receive a high standard of care at the end of life and have the opportunity to make informed choices about where they wish to die.

Evidence shows that around half the annual 500,000 deaths in England currently occur in acute hospitals, with people spending an average of 18 days in-patients during the last year of their life, often spread over several admissions.

The reasons why people die in hospital are complex and multi factorial but we know, certainly at the beginning of the disease process, that most people would prefer to die in their own homes, a care home, or a hospice. This requires people and their families to be involved in decision making and planning for the end of life, and for appropriate community based support and care to be put in place.

During the last year the palliative care team has worked hard to ensure that they discuss preferred place of care with palliative care patients and that this is recorded. The Trust reviewed its practice against a target set by its commissioners being at least 60% of patients and the table below demonstrates the results on this work

Quarter 1	Quarter 2	Quarter 3	Quarter 4
58%	79%	83%	69%

This demonstrates that the Trust performed well and has steadily improved across the year.

Lung Cancer Pathway
Milton Keynes Hospital is one of just a few hospitals in the country to offer a same day lung cancer referral. In many other areas, waiting for tests and results can take several weeks. As with most cancers, early diagnosis

and treatment can make a significant difference in surviving the disease. Fortunately, most patients discover they don't have cancer and getting quick results saves the patient and their family weeks of stress and anxiety.

Management of Pleural Disease
Usually, patients needing treatment for fluid around the lung would be admitted for up to a week. Now, instead of being admitted, a patient has all the tests they need and the necessary treatment on the same day; they are home by the afternoon. Not only does this save bed days, but the process is Consultant-led, as recommended by the National Patient Safety Agency (NPSA) and it provides excellent training opportunities for other clinicians.

Redesigned pathway for bronchcoscopy
Patients having a bronchcoscopy, which helps diagnose lung cancer or infections like TB, are seen as a day case. Patients are treated and go home more quickly; they go straight to the Endoscopy unit to have the procedure and are able to go home as soon as is appropriate after the procedure.

Home Oxygen Service
The hospital has worked with colleagues at Milton Keynes Community Health Services to provide high-quality care for patients needing oxygen at home. The service helps patients with conditions such as Chronic Obstructive Pulmonary Disease (COPD) better manage their condition in their own home and prevent exacerbations and admission to hospital.

Safeguarding Vulnerable Adults
The Healthcare Commission Audit into Dementia Care and the National Confidential Enquiry into Patient Outcome and Death review of the care received by elderly patients undergoing surgery both identified a number of concerns about the level of care received nationally. In addition to this the Care Quality Commission has produced six clinical indicators of effectiveness of hospital care for people with learning disabilities. This year the Trust have worked hard to ensure 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. The Trust set up a Safeguarding Vulnerable Adults group who have been responsible for reviewing national guidance and improving compliance with best practice. Performance has been assessed by a number of measures which included:

- completion of a Mental Capacity Assessment for patients whose capacity is of concern with appropriate referral for specialist review; and
- the improvement and monitoring of staff training.

Pressure Ulcer Prevention
It was estimated in 2004 that the NHS in the UK spent between £1.4-2.1bn on treating pressure ulcers. This was a conservative estimate, and of this 90% of this cost is nursing time.[1] Evidence[2] suggests that between 4-10% of patients into UK district hospitals develop a pressure ulcer.

The focus for the Trust (2011/12) was to continue the work started in previous years on the reduction of newly acquired grades 3 and 4 pressure ulcers and to:

1. Improve training; and
2. Improve investigation processes and share learning from these; and
3. Maintain the low levels of pressure ulcers reported during 2010/2011.

The Trust Continues to take a Proactive approach in the reduction of hospital acquired pressure ulcers. The Tissue Viability Service has supplied relevant supplementary information to the Trust Commissioners & PCT in relation to the patients' origin of and grade of pressure ulcers within the hospital and community setting.

The Pressure Ulcer CQUIN for 2011/2012 at present we have achieved this target which will enable the Trust to receive a CQUIN payment .NHS Milton Keynes have recognised and complimented the Trust on its achievement in regards to the improvement in prevention treatment and management of pressure ulcers.

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[1] The cost of pressure ulcers in the UK. Age and Ageing, Vol33 No3 2004

[2] Does quality save money? Health Foundation 2009

The Trust was part of South Central Health Authority and proactively worked to raise awareness regarding pressure ulcer prevention and management to patients, carers, relatives, nursing staff and other allied health care professionals.

In January 2012, the Trust received notification from the East of England Strategic Health Authority informing us that the Trust would be participating in the use of the National NHS Safety Thermometer which is to be incentivised through CQUIN. The Trust is to participate in a monthly prevalence audit of all patients to identify the number of falls, VTE, Urinary Infections (UTI) and Pressure Ulcers which are hospital acquired.

In addition, the elimination of all Grade 2, 3 & 4 Pressure Ulcers are to be achieved by December 2012.

Venous Thromboembolism (VTE)
VTE is a significant cause of mortality, long-term disability and chronic ill health. It was estimated in 2005 there were around 25,000 deaths from VTE each year in hospitals in England and VTE has been recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team. The Trust has worked hard to ensure that in line with guidance from the National Institute for Health Promotion and Clinical Excellence (NICE) all adult inpatients have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool.

How did we perform in 2011/12?

Safeguarding Vulnerable Adults
The Trust has achieved a lot over the past year but audit results do demonstrate that further work is required to increase understanding around mental capacity by further embedding of training in practice.

Pressure Ulcer Prevention
Number of newly acquired grade 3 and 4 pressure ulcers reported across the Milton Keynes Health Economy is reported in the table below:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
Grade 3 = 0	Grade 3 = 1	Grade 3 = 2	Grade3 =1
Grade 4 = 0	Grade 4 = 0	Grade 4 = 0	Grade 4 =0

Venous Thromboembolism (VTE)
Glose Dias – Debbie has emailed
The Trust's target was to ensure that 90% of patients received a VTE assessment in line with National guidance. The table below demonstrates the Trust's performance with this over the year.

Quarter 1	Quarter 2	Quarter 3	Quarter 4
80.3%	88.16%	93.3%	TBC

Patient Safety

Priority 2: To continue to build on to the quality improvements in maternity services.

Why was this a priority?
We felt it was important to not lose focus on the ongoing key priorities for maternity services of the previous year for 2010/11 in 2011/12.

What did we do in 2011/12?

- Recruited a full midwifery staffing establishment to ensure we can offer care within a 1:30 midwife to birth ratio;
- Established a Labour Ward 'daily case' Review Meeting to learn from clinical events and promote multidisciplinary team working;
- A SBAR handover tool was implemented to ensure more accurate risk assessment and communication of high risk patients during handovers;
- A Medicines Management work-book is in place for all midwives to assess clinical competencies;
- The 'Protected Week' training for midwives has been reviewed and updated with a new individual staff competency assessments in place;
- A Triage service for early labouring women has been developed to ensure women are appropriately managed either in hospital or at home;
- A new 'Aromatherapy Service' has been introduced into the Community to provide women accessing maternity services at the hospital more choice and control over their pregnancy and labour. This offers a non-pharmacological treatment for physiological discomfort;

- Antenatal education for women has been reviewed, updated and re-launched;
- Maternity Services achieved Clinical Negligence Scheme for Trust Level 1 Risk Management Standards;
- We have expanded midwifery service from Children's Centres to provide more care locally; and
- The results from the National Maternity Survey showed improvement, this was reflected in our internal Maternity Survey when we asked woman about the care and support they received during labour; An average satisfaction rate of 97% was maintained throughout the year;

How did we perform in 2011/12?
Overall, Maternity Service continues to perform very well against its Key Performance Indicators (KPIs) to ensure high quality of care is given. Year on year improvements have been made to improve the normal birth rate and 64.6% was achieved for 2011/12 against a CQUIN target of 65%.

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

Why was this a priority?
It is vital that we do everything we can to reduce the likelihood of patients getting an infection whilst they are in hospital as a result of the care they receive.

What did we do in 2011/12?
Over the year we undertook a number of key actions to continue to improve our infection prevention and control. These included:

Over the year we undertook a number of key actions to continue to improve our infection prevention and control. These included:

- Remained within our target for both MRSA bacteraemia (blood stream infection) at 2 cases during the reporting period and 16 cases of Clostridium difficile. (The maximum permitted was 2 cases of MRSA and 32 of C diff).
- The investigation into cases of MRSA bacteraemia and Clostridium difficile benefits from a shared approach between the Trust and the local Community Infection Prevention and Control Team. Information on patients with a positive result for Clostridium difficile and or MRSA status being admitted to the hospital or discharged home is shared between the two teams. All patients thought to be at high-risk (people who need through-the-skin medical devices like long lines or devices such as urinary catheters) are monitored continuously by the Trust and, where required, the patient's GP is alerted as is the Community Infection Prevention and Control Nursing Team to ensure appropriate care is continued to reduce the potential for further complication to occur once the patient has left hospital.
- Staff compliance with the Antibiotic policy remains under constant surveillance, 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 Director of Nursing, the Medical Director, and the Associate Medical Director both Consultant Microbiologists, the infection prevention and control nurse team, a dietitian and a gastroenterologist.

How did we perform in 2011/12?
By the end of the year, our increased vigilance and focus meant that we remained within our target for both MRSA bacteraemia (blood stream infection) at 2 cases during the reporting period and 16 cases of Clostridium difficile. (The maximum permitted was 2 cases of MRSA and 32 of Clostridium difficile).

Patient Experience

Priority 4: Ensuring people have a positive experience of care.

Why was this a priority?
We know it is crucial to have a clear understanding of how our patients feel about our services if we are to meet their expectations and provide a first class patient

experience. Being more accountable to what our patients are telling us means we will make the right improvements to meet their needs.

What did we do in 2011/12?
We introduced a lot of new ways of doing things to ensure patients received high-quality and safe care.

How did we perform in 2011/12?
98% of our patients felt they were involved in decisions about their care and treatment; this is an improvement to last year (90%).

We have only had one reportable breach of the Same Sex Accommodation rules, compared with 29 last year.

83% of stroke patients spent the majority of their stay on the Stroke Ward receiving the specialist care there needed.

Patient's length of stay in hospital has reduced as a result of improved and more efficient care pathways.

The hospital have improved the management of Operating Theatre time and the number of cancelled operating sessions has dropped by two-thirds from 291 cancellations last year to 91 this year.

The hospital is cleaner than ever, with domestic cleanliness ratings increasing from 82.3% last year to 92.3% this year

Analysing the cost benefit of patient care helped Physiotherapists to identify where their intervention could help patients and save money; a patient previously receiving twice daily assistance from Carers benefited from physiotherapy which enabled her to access the toilet herself. The physiotherapy sessions cost £950, compared to £9,869 per year for the Carer visits for toileting. The patient said: "I'm no longer under pressure to have a wee between 10.30 and 10.45 and 3.15 and 3.30!"

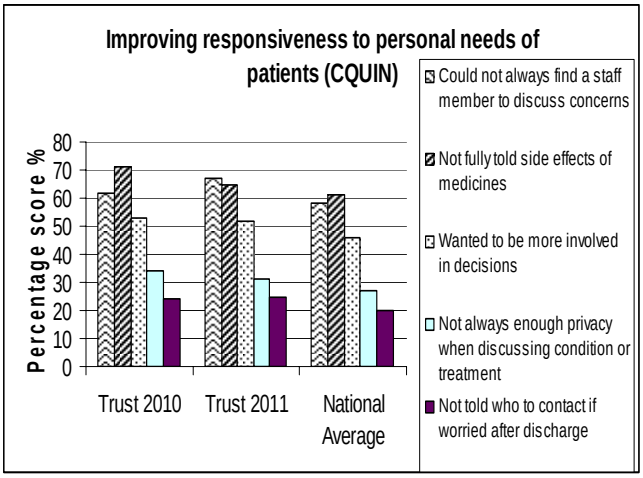
Our Internal and National Surveys identified the following areas for improvement.

- Our inpatient surveys highlighted that we continue to improve in the areas of:
  -Information and Communication;
  -Staffing;
  -Current practice and processes; and
  -Environment

Our outpatient survey results identified areas related to communication and action plans are being progressed to monitor improvement and will form part of the work on our 'Key Quality Priorities' going forward in 2012-13. Comparison with the results of previous surveys has already shown improvement.

In response to the results of the Picker 2010 Inpatient Survey, an action planning group was formed to find ways of improving patient experience. It identified some long-term challenges but also some short term quick fixes. The results highlighted that the patients were not always aware of the positive things being done in the background and that this information was not shared enough. Staff and patient information leaflets were developed to address these issues.

The Picker Inpatient Survey also highlighted an improvement in 3 out of 5 questions related to CQUIN indicators. The graph below demonstrates this.



Note: Lower scores are better

The national maternity survey showed improvement, this was reflected in our internal maternity survey when we asked women about the care and support received during labour. An average satisfaction rate of 97% was maintained throughout the year.

Statement of Assurance from the Board

These statements of assurance follow the statutory requirements for the presentation of

Quality Accounts, as set out in the Department of Health's Quality Accounts registration.

Review of Services

During 2011-12 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.

'Reviewing the data' means having a rolling plan agreed by board, clinicians and stakeholders – should be element of challenge or peer review built into data review.

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 2011-12.

Participation in clinical audit and review

Clinical audit is a simple tool to review clinical practice against best evidence standards identifying actions to improve the quality of patient care and treatment.

National confidential enquiry is a form of national clinical audit looking at potentially avoidable factors associated with poor outcomes.

During 2011-12 39 national clinical audits and 4 national confidential enquiries covered NHS services that Milton Keynes Hospital NHS Foundation Trust provides. This section details our participation in these.

During 2011-12 Milton Keynes Hospital NHS Foundation Trust participated in 76% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Milton Keynes Hospital NHS Foundation Trust was eligible to participate in are as follows: see Figures 1 and 3 below.

The national clinical audits and national confidential enquiries that Milton Keynes Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2011-12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry are identified in the tables below.

The reports of 39 national clinical audits were reviewed by the provider in 2011-12 and Milton Keynes Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Fig 1: National Clinical Audits 2011-12

Name of audit	Eligible to Participate	Participated	% Cases Submitted
Peri-and Neo-natal			
Perinatal mortality (MBRRACE-UK)	Yes	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	Yes	100%
Children			
Paediatric pneumonia (British Thoracic Society)	Yes	Yes	In progress
Paediatric asthma (British Thoracic Society)	Yes	Yes	
Pain management (College of Emergency Medicine)	Yes	Yes	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	Yes	

Paediatric intensive care (PICANet)	No		
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No		
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	100%
Acute care			
Emergency use of oxygen (British Thoracic Society)	Yes	No	
Adult community acquired pneumonia (British Thoracic Society)	Yes	No	
Non invasive ventilation -adults (British Thoracic Society)	Yes	Yes	
Pleural procedures (British Thoracic Society)	Yes	No	
Cardiac arrest (National Cardiac Arrest Audit)	No		
Severe sepsis & septic shock (College of Emergency Medicine)	Yes	Yes	100%
Adult critical care (ICNARC CMPD)	Yes	tbc	
Potential donor audit (NHS Blood & Transplant)	Yes	Yes	
Seizure management (National Audit of Seizure Management)	Yes	Yes	
Long term conditions			
Diabetes (National Adult Diabetes Audit)	Yes	Yes	100%
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes	24%
Chronic pain (National Pain Audit)	Yes	Yes	
Ulcerative colitis & Crohn's disease (UK IBD Audit)	Yes	Yes	
Parkinson's disease (National Parkinson's Audit)	Yes	tbc	
Adult asthma (British Thoracic Society)	Yes	No	
Bronchiectasis (British Thoracic Society)	Yes	tbc	
Elective procedures			
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes	
Elective surgery (National PROMs Programme)	Yes	Tbc	
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No		
Liver transplantation (NHSBT UK Transplant Registry)	No		
Coronary angioplasty (NICOR Adult cardiac interventions audit)	No		
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes	
Carotid interventions (Carotid Intervention Audit)	Yes	Yes	100%
CABG and valvular surgery (Adult cardiac surgery audit)	No		
Cardiovascular disease			
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes	
Heart failure (Heart Failure Audit)	Yes	On hold	
Acute stroke (SINAP)	Yes	On hold	
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Yes	tbc	
Renal disease			
Renal replacement therapy (Renal Registry)	No		

Renal transplantation (NHSBT UK Transplant Registry)	No		
Cancer			
Lung cancer (National Lung Cancer Audit)	Yes	Yes	
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	tbc	
Head & neck cancer (DAHNO)	Yes	tbc	
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	tbc	
Trauma			
Hip fracture (National Hip Fracture Database)	Yes	Yes	~50%
Severe trauma (Trauma Audit & Research Network)	Yes	Yes	
Psychological conditions			
Prescribing in mental health services (POMH)	No		
Schizophrenia (National Schizophrenia Audit)	No		
Blood transfusion			
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	Yes	
Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes	Yes	
Health promotion			
Risk factors (National Health Promotion in Hospitals Audit)	No		
End of life			
Care of dying in hospital (NCDAH)	Yes	Yes	In progress

Fig. 2 Optional National Clinical Audits carried out

Topic
Breast Cancer Clinical Outcome Measures (BCCOM)
Mastectomy & Breast Reconstruction Audit (NMBA)
National Vascular database (including Abdominal Aortic Aneurysm records)
Urology Cancers (BAUF)
Inpatient Audit of Children with Diabetes (HQIP)
Surgical site surveillance audit (SSI) THR Jan – Mar 2012
An Age Old Problem (NCEPOD)
Knowing the Risk (NCEPOD)
Patient satisfaction following combined orthoganthic surgery and orthodontic treatment (optional National audit)
Use of Chlorprep in association with SSI for colorectal surgery

Fig. 3 National Confidential Enquiries

Topic	Eligible to participate	Participated	% cases submitted
Bariatric Surgery	Yes	Yes + Organisational Questionnaire Submitted	No cases matched the criteria for inclusion
Cardiac Arrest Procedures	Yes	As above	5
Peri-operative Care	Yes	As above	6
Surgery in Children	Yes	As above	No cases matched the criteria for

			inclusion

Fig 4 National and Local Clinical Audits Reviewed

Audit Report	Areas of action
Bleeding in Early Pregnancy	The Bleeding in Early Pregnancy Care pathway was reviewed and refinements made as a result of audit findings; a subsequent audit has taken place and the results demonstrated improvement.
Audit of NICE Guidance 'Transient Loss of Consciousness'	This audit identified the need for the pathway of patients attending the Emergency Department (ED) with a history of collapse to be refined. The pathway has been refined in line with National Guidance from NICE.
Audit of the standard of documentation of Do Not Attempt Resuscitation CPR orders.	An audit was carried out following a complaint. A poster has been created to encourage doctors to follow recommendations. A DNA CPR questionnaire has been designed to test awareness of staff following guidance. A second audit is planned to test learning in practice.
Dietetic audit on use of Malnutrition Universal Screening Tool (MUST) score on wards	Resulted in additional training for staff to ensure completion.
Domiciliary physiotherapy documentation audit	Resulted in staff awareness training to highlight issues of non-compliance with trust policy.
Pre-operative fasting audit.	New trust policy for fasting guidelines for emergency cases was developed. Staff awareness and education; and Posters, Screensavers and Nurse teaching sessions were introduced to improve practice. Introduced improved communication between ward staff and theatre bleep holders to tailor fasting times to individual patients.
Awareness amongst midwives about epidural analgesia assessment.	Laminated observation guidelines have been placed in each Labour Room to ensure easy access to evidence best practice guidance. Laminated dermatomal boards have also been placed in each room. Midwifery training and teaching initiated by Obstetric Anaesthetic. A re-audit is planned in 1 year.
An Audit of Medicines Reconciliation (MR) at MKHFT (April 2011)	Documenting the date and time of completing the MR on the prescription chart. Documenting the source(s) of information used to complete the MR on the prescription chart
An Audit of the Use of Bungs in Liquid Controlled Drugs (CD) stocked on wards at MKHFT (February 2012)	Ward not currently using bungs to change to this practice with immediate effect. Checking for presence of bungs in CD liquids to become regular feature of 3 monthly CD checks.
DVT prophylaxis with pradaxa	Continue low dose regime.
Thermal chondroplasty for	Continue with current practice.

patellofemoral pain	
PIC line insertion	Review infected cases requiring PIC line ongoing.
Time to CT scan for major trauma	Achieves target level 2 trauma centre.
Use of VTE risk assessment within Maternity	Review of the current guidance to ensure it clearly describes the process in place. Review of the current proforma to include the facility to indicate when no risk factors exist. To re-audit the entire process in 6 months to provide further assurance to the maternity service that all women are having the appropriate risk assessments undertaken and the correct actions are being taken in response to the risk assessments. To give feedback to all staff on the results of the audit to ensure learning is in place.
Febrile Neutropenia	Antibiotics must be given within one hour of arriving. Patients have now been given a parent held card for them to present to hospital with this information. Actual time of arrival on Paediatrics Day Assessment Unit to be recorded.
VTE assessment in elective gynaecological surgery (Re-audit)	Improvement seen. VTE Assessment in Surgical Assessment Unit (ASU) needs further improvement. Reassessment is important and needs to be completed. Wards only allowing transfer if VTE completed. Continue to emphasise to SHOs and SpRs at Induction. Add column for VTE Assessment on Patient List. Look at the reassessment box for each patient whenever drug chart reviewed.
Eye Clinic activity audit	Speciality codes should be assigned to each patient episode to ensure accurate activity report
WHO compliance	Post procedural briefings need to focus in more detail on the positive & negative aspects of the respective procedure. WHO checklist review in relation to accountability signature
Late starts	Change to time of WHO checklists & review of operational working in Theatres to maximise capacity. Introduction of SDAU
Monitoring of Named Nurse for Paediatrics	Noted effective use of new paediatric processes/documents. For on going monitoring.
ED wrist x-rays (T&O)	Negative wrist injuries investigated with MRI which picked up a significant amount of pathology, & combined with follow up in the ED clinic provided a very commendable service
Visual Analogue Scores for the 24 post operative hours of patients undergoing total hip or knee replacement	Review of enhanced recovery pathway (ERP) pain management & inclusion of peri-articular injections. Re-audit planned.
Time taken for PICC line insertion	Delays were due to unavailability of appropriate radiologically trained staff – feedback to Radiology Team to improvement in service.
Retrospective radiological audit of halux valgus	Need to include outcome measures in surveillance of patient satisfaction post treatment
Patient Satisfaction with Junior Doctors	Noted patients are sometimes given conflicting information due to being seen by too many doctors. Patients unaware of doctors' details & grade. Patients unaware who to contact if problems arise post discharge. Implement new practice with ongoing audit to measure improvement.
Management of acute urinary retention	Implementation of Trust urinary retention protocol to improve management.
30 day return to theatre	Continue to monitor all return to theatre cases as a means to improve documentation of all morbidities cases.

Appropriateness of Consent in Laparoscopic Cholecystectomy: a Cross-Sectional Audit	Patient questionnaire study suggested most patients have not noticed a worse Quality of Life after a negative appendicectomy, therefore plan for a further audit and to implement the Alvarado Scoring to assist with diagnosis of right iliac fossa pain and to improve accuracy.
Adherence to antibiotic policy (Surgical Assessment Unit ASU)	Recommendation that concurrent use of Metronidazole and Co-amoxiclav is only used when the patient has been seen by a Registrar/Consultant & the decision is made by him or her personally. Intravenous antibiotics are only prescribed following the review of the patient's blood tests and vital signs. That all intravenously prescribed antibiotics should be reviewed by all medical teams after two days of treatment, with the aim of switching to oral if there are no contra-indications
Pre-assessment patient satisfaction audit	Ongoing (draft) Trust starvation policy being managed by Anaesthetics.
TTO (Take-away medicines) audit	Timely proactive prescribing of TTO to minimise discharge delays.
Colorectal anastomosis leak audit	To revert back to bowel prep on the ERP pathway in light of increased trend for anastomosis leaks.
Audiology patient satisfaction audit	Recommendations in relation to notifying patient when clinics are running late & responding to patients phone messages
Audit of Antenatal Notes	Review the antenatal pathway and give all generic information leaflets at booking. Risk assessments to be completed. BMI to be recorded. Signature to be provided. Re-audit in 6 months.
Third and fourth degree tears	Most cases of third and fourth degree tears managed appropriately in terms of pre-operative and intra-operative management. Post-operative management improvements include DATIX forms being completed and 6 week post-op follow-up must be arranged.
Post caesarean Section wound infections	Maximal barrier precautions to be adhered to: Sterile gloves, gown, mask, cap, drape. Increased scrutiny of compliance with risk reduction intervention, Hand hygiene, washing and sterile techniques. Clear guidance on use of sutures/staples to be looked at.
Febrile Neutropenia in Children	Antibiotics must be given within one hour of arriving. Patients have now been given a parent held card for them to present to hospital with this information. Actual time of arrival on Paediatrics Day Assessment Unit (PDAU) to be recorded.
Perinatal management of infants born to HIV positive women	Continue to use the baby alert forms. Each baby should have a comprehensive plan included on the baby alert preferably in step wise tick box. The guideline on the intranet is relabelled to ensure it is easy to locate. Consider formal referral arrangements to Milton Mouse day unit and its documentation in notes. Consider a flow sheet/checklist to be completed as an aid memoir and as documented evidence of care and treatment given. Each baby must be made its own set of notes and Mother's blood results documented in these.
Syphilis	All patients diagnosed are referred to Health Advisor (HA) at every visit. Offer provider referral as first line partner notification. Confirm contacts attendance at our or other sexual health clinics. Continue annual audit. Document contact tracing plans and outcomes in patients records, so all staff are aware if there are incomplete contact tracing issues that need to be addressed when the patient next attends.
Management of postmenopausal bleeding	Elimination of the unnecessary procedures - endometrial sampling, CA 125. Consider direct referral of the patients with endometrial thickness more than 10 mm for in-patient hysteroscopy. Develop local guideline for the management of

	postmenopausal bleeding. Re-audit in 6 months.

Participation in Clinical Research
The number of patients receiving NHS services provided or sub-contracted by Milton Keynes Hospital NHS Foundation Trust in 2011-12 that were recruited during that period to participate in research approved by a Research Ethics Committee was 702**.**

Additional information
The number above represents patients recruited to studies that were adopted onto the National Institute for Health Research (NIHR) Portfolio. This figure compares to 441 being recruited in the previous year.

There were 44 clinical staff participating in research approved by a Research Ethics Committee at Milton Keynes Hospital during 2011-12, (3 more than in the previous year), comprising Principal Investigators, research nurses and local collaborators. These staff participated in research covering a range of different medical specialties, including Cancer, Medicines for Children, Diabetes, Stroke and Dementia and Neurodegenerative Diseases. The Trust was involved in recruiting to 62 NIHR portfolio and 14 non NIHR portfolio clinical research studies during 2011-12; and during this period, 12 studies obtained permission to start through the National Coordinated System for gaining NHS permissions (CSP), representing an increase of 8 studies compared to the previous year.

Our engagement with clinical research demonstrates our commitment to testing and offering the latest medical treatments and techniques. The following research studies, opened during this period, gives an example of the Trusts commitment to improving patients' experiences and their quality of care:

A trial looking at imatinib and dasatinib for newly diagnosed chronic myeloid leukaemia (SPIRIT 2)
This trial compares two drugs - imatinib and dasatinib, for chronic myeloid leukaemia that has been recently diagnosed in chronic phase. The trial aims to find out if dasatinib is better than imatinib for people with newly diagnosed chronic myeloid leukaemia, and to understand more about the side effects.

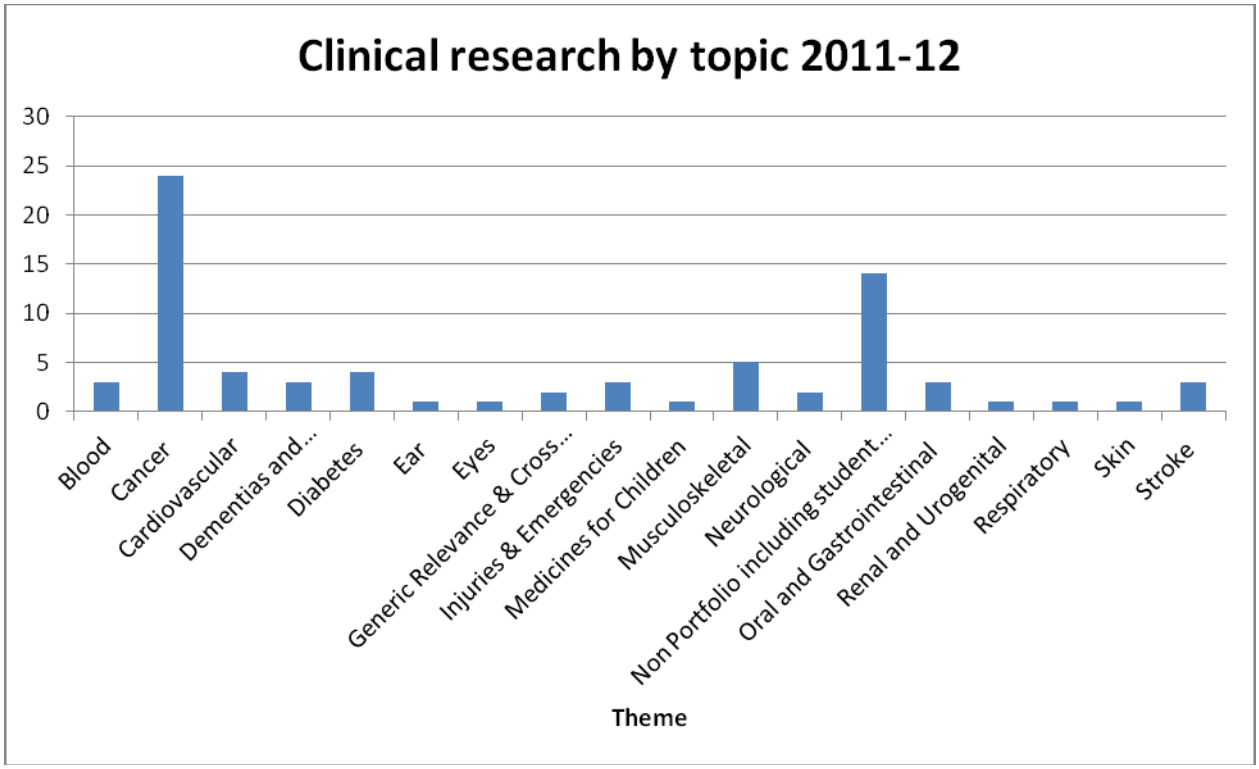
Efficacy of Nitric Oxide in Stroke (ENOS)

This trial aims to assess what effect glyceryl trinitrate (or GTN) has on how well people recover from strokes. GTN is a tried and tested drug in other medical conditions that acts quickly to relax blood vessels and lowers blood pressure. The data will help doctors decide whether blood pressure lowering treatments like GTN can be used in patients with acute strokes to try and improve recovery.

Total or Partial Knee Arthroplasty Trial (TOPKAT).
Patients with osteoarthritis of the knee undergo a joint replacement – this can be either a 'total' or a 'partial' knee replacement. Both types of operation are practiced and well established yet it is not clear which is most effective.

This study compares 'total' with 'partial' knee replacements in patients with knee arthritis to find out which operation is the best treatment in the long term.

The Research & Development page on the Trusts website is in the process of being updated, which will be much easier for patients to gain more information about clinical research studies that are open and available to join. In addition, patient appointment letters will shortly be re-worded to highlight that the Trust is research-active, and that patients may be asked if they wish to take part in clinical research.


Clinical research by topic 2011-12
30
25
20
15
10
5
0
Blood
Cancer
Cardiovascular
Dementias and...
Diabetes
Ear
Eyes
Generic Relevance & Cross...
Injuries & Emergencies
Medicines for Children
Musculoskeletal
Neurological
Non Portfolio including student...
Oral and Gastrointestinal
Renal and Urogenital
Respiratory
Skin
Stroke
Theme

Regulatory requirements

Care Quality Commission (CQC)

In January 2011 the CQC visited Milton Keynes Hospital and found that 'on ward 20, patients were deemed at risk by staff's failure to follow infection prevention and control procedures'. Major concerns were registered by CQC and the Trust was required to address these findings. Following implementation of an action plan and a series of internal self-assessment mock CQC inspections the Trust reported that it believed it had achieved compliance in June 2011.

An unannounced visit on 21st September 2011 was made again by the CQC and Inspectors revisited Ward 20 and found that although improvements had been made, full compliance with IPC had not been achieved. The inspectors specifically reported on incidences of non-compliance involving two individuals and issues of non-compliance related to the transport and storage of clinical waste. A Warning Notice was issued to the Trust on 27th September 2011.

A detailed action plan was drafted to respond to all of the issues raised in the CQC Warning Notice to enable the Trust to deliver fully on all of the recommendations and continue to embed improvements in IPC throughout the whole Trust.

In response to the CQC Warning Notice, the Trust developed an action plan in consultation with key internal stakeholders. This action plan was shared with the CQC, the Primary Care Trust (PCT) and the Strategic Health Authority (SHA) on 10 October 2011. A further review was undertaken by the CQC and the Trust is now compliant.

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.

Monitor

We started the year with a red governance rating from Monitor, the Foundation Trust regulator having found the Trust in significant breach of condition 5 of our terms of authorisation on 2 March 2010. This related to 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.

Data Quality

(Billy Aspinall/Jill Patterson – update available in April) Milton Keynes Hospital NHS Foundation Trust will be taking the following actions to improve 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 2011-12 was 81% and was graded "green" for all categories except Corporate Records. The requirements fall under the Trust's Secretary's remit, however this post has only just been filled with a substantive member of staff. This remains on the Information Governance Risk Register and will be monitored closely by the Information Governance Steering.

Insert Grant Thornton's assessment of scrutiny on the development of accounts.

Care Quality Commission (CQC)

(Kay Taft)

Milton Keynes Hospital NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011-12:

- To update

Milton Keynes Hospital NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

Milton Keynes Hospital NHS Foundation Trust has made the following progress by 31st March 2012 in taking such action: To update.

Further Performance information

Trust Board Quality Measures: *To check this with current Dashboard

This table covers two pages.

PATIENT SAFETY	Measurement used	Performance			
		2008-9	2009-10	2010-11	2011-12
Hand hygiene compliance	Internal target – percentage compliance as measured by Matrons' Audits	69.1%	89.9%%	95.2%	96.9%
Hospital-acquired pressure ulcers (grades 3 and 4)	Internal target – total number measured by Matrons' Audits	8	6	9 (grade 3 only)	4 (grade 3 only)
Patient falls	Internal target – total number of reported incidents.	577	664	669	588
Medication incidents	Internal target – total number of reported incidents.	179	369	554*	474
Serious incidents (Julieann Carter/Kay Taft	Internal target – total number of reported incidents.	37	35	44	*To be confirmed
'Never' events	This is a based on a nationally accepted list of events published by the National Patient Safety Agency.	0	0	0	*To be confirmed
CLINICAL EFFECTIVENESS	**Measurement used**	**Performance**			
		2008-9	**2009-10**	**2010-11**	**2011-12**
Hospital standardised mortality ratio (HSMR): all (Jill Patterson)	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	*To be confirmed
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.	Perinatal rate 5.4 per 1,000 Stillbirth 5.1 per 1,000
CLINICAL EFFECTIVENESS	**Measurement used**	**Performance**			
		2008-9	**2009-10**	**2010-11**	**2011-12**
Readmissions under 14 days (elective)	Emergency admissions within 14 days of elective discharge, including day cases. Internally set	Under 3.3%	5%	2.3%	2.3%

	target				
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%	10.2%
PATIENT EXPERIENCE	**Measurement used**	**Performance**			
		2008-9	**2009-10**	**2010-11**	**2011-12**
Informal complaints from patients	The number of informal complaints from patients received by the Trust	264	136	343	475
Formal complaints	The number of formal (written) complaints from patients received by the Trust	304	354	300	246
Midwife : birth ratio	Birth Rate Plus Midwifery Workforce planning tool	1 to 40	1 to 30	1 to 30	1 to 30
WORKFORCE	**Measurement used**	**Performance**			
		2008-9	**2009-10**	**2010-11**	**2011-12**
Staffing level incidents	Internal target – total number of reported incidents	1013	199	193	199
Incidents of violence towards staff	Internal target – total number of reported incidents	222	82	79	46

*The increase in number of Medication Incidents during 2010-11 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.

The number of incidents has continued to hold steady in 2011-12 as the awareness training is ongoing with new staff. Also in 2011-12 there has been a rise in Allied Health Professional staff reporting leading to a similar reduction in medical staff reporting, most incidents occur in the administration of medicines leading to errors, delays and omissions.

Performance against key national priorities and regulatory requirements 2008 to 2012

Note: we have included performance in previous years 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 three pages.

Indicator	Target and source (internal/regulatory /other)	Achievement			
		2008-9	2009-10	2010-11	2011-12
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	>96% set by Monitor	Achieved	Achieved (98%)	Achieved (99.7%)	Achieved (98.72%) Q1-3, Q 4 unvalidated until 5.5.12
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	>85% set by Monitor	Achieved	Achieved (98%)	Achieved (92.3%)	Achieved (87.51%) Q1-3 Q4 unvalidated until 5.5.12
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%)	Achieved (98.98%) Q1-3 Q 4 unvalidated until 5.5.12
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%)	Achieved (99.17%) Q1-3 Q 4 unvalidated until 5.5.12
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%)	Achieved (96.84%) Q1-3 Q 4 unvalidated until 5.5.12
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%)	Achieved (97.86%) Q1-3 Q 4 unvalidated until 5.5.12

Indicator	Target and source (internal/regulatory /other)	Achievement			
		2008-9	2009-10	2010-11	2011-12
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	Admitted: achieved (91.1%), RTT Specialty: achieved 9/19 (only 13 relevant) Non-admitted: achieved (99.0%), RTT Specialty: achieved 19/19 (only 15 relevant)
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%)	96.3%
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)	Not applicable. Service not provided.
Rapid Access Chest Pain Clinic % seen within 2 weeks	100% Set by Care Quality Commission	Achieved	Achieved (100%)	Achieved (100%)	100%
Genito-urinary medicine clinics: % appointments available within 48 hours	100% set by Care Quality Commission	Achieved	Achieved (100%)	Achieved (100%)	100%
Cancelled operations: %age readmitted within 28 days	>95%	Achieved	Achieved (100%)	Achieved (99%)	96%

Indicator	Target and source (internal/regulatory /other)	Achievement			
		2008-9	2009-10	2010-11	2011-12
Clostridium Difficile infections in the Trust	Set by DH /SHA	Achieved (43 against trajectory of 117)	Achieved (31 against 81)	Achieved (33 against 56)	Achieved to date (16 against 32)
MRSA bacteraemia (in Trust)	7 set by the DH/SHA	Achieved (6 against a trajectory of 7)	Achieved (1 against 6)	Achieved (1 against 4)	Achieved to date (2 against 2)
MRSA bacteraemia (across Milton Keynes total health economy)	10 agreed locally	10	3	6	Achieved to date (5 against 4)

Note: CDiff and MRSA figures updated against those reported in the Quality Account last year as Health Protection Agency statistics differed from local data.

Insert final year position:
Board Scorecard
Insert Quality Scorecard
Insert CQUIN Scorecard

Who we have involved to develop our Quality Account for 2012-13

Development

The development of the Quality Account has been led by the 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: *to confirm via consultation and communications plan process.

- Chief Executive;
- Medical Director;
- Director of Nursing;
- 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.

Consultation and Communication
The Trust developed a Consultation and Communication Plan with an aim to ensure**…..*cross reference with the Communication draft plan and insert.**

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

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

The report was also sent for comment to:
*Insert dates

- GP Consortia
- NHS: Milton Keynes
- Link:MK – Presentation via Patient, Public and Staff Experience Committee (as above) and formal circulation
- Milton Keynes Council Health and Community Select Committee

Statements provided by Commissioner, LINks and Local Council

Statements provided by NHS: Milton Keynes (our commissioner), LINks: MK and Milton Keynes Council Health and Community Wellbeing Select Committee can be found in full in the Annex to this document.

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:

Kay Taft
Head of Clinical Governance &
Risk Management
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

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

To insert

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

To insert

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

To insert

ANNEX B – 2011-12 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 2011 to June 2012;
  - Papers relating to Quality reported to the Board over the period April 2011 to June 2012;
  - 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