



## Quality Account 2014/2015

**WeCARE**

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## Part 1: The Quality Account

### 1.1 Statement on quality from the Chief Executive

I am delighted to introduce the Quality Accounts for Milton Keynes University Hospital NHS Foundation Trust, which provides us with the opportunity to reflect on our quality achievements and successes over the past twelve months as well as to identify areas for further improvement, including our quality priorities for the coming year.

Our top priorities at Milton Keynes University Hospital NHS Foundation Trust are to improve patient safety, clinical effectiveness and the patient experience.

During the last year the Trust:

- cared for 55,238 inpatient
- cared for 320,026 outpatients
- attended to 78,388 people in A&E
- delivered 3,802 babies
- were paid £167million for our services

We have made tangible improvements in the care that we provide at Milton Keynes Hospital throughout the year and we will continue to put the patient at the heart of further planned development over the coming months.

In October the Care Quality Commission visited the Trust to formally inspect and assess the quality of the care we provide, with the report published in March.

Six of the eight areas assessed were judged overall to be 'good' and the Trust was one of the few hospitals in the country to receive a rating of 'outstanding' for being 'well-led' in its surgical services. Areas overall that were rated good included critical care, maternity and gynaecology, services for children and young people, end of life care, outpatients and diagnostic imaging.

Despite having some good areas identified in the report, two areas - urgent and emergency services and medical care - were rated as 'requires improvement' overall.

Although the hospital had more than 80% of its areas rated good or outstanding, we received an overall rating of 'requires improvement'. Whilst this was disappointing to many, this was a fair and balanced report which identified those areas we know we need to continue to develop and improve as well as those already good, which we can move to outstanding.

Demand for A&E has continued to prove challenging this year, as physical space still remains a limiting factor. In 2014-15 the Trust was awarded £2.9million to expand the clinical space to help us manage the ever-increasing workload in our A&E department, where the number of patients is increasing every year.

We have already started work on an expansion of clinical areas, taking place over two phases. In December 2014 we completed a clinical expansion in A&E, creating five new bed bays for patients. Following on from this in spring 2015 we are starting a larger, second phase to create a significant expansion of clinical space for assessment work, which we expect will be completed in October 2015.

In addition to the challenges we face with A&E, we continue to have significant numbers of patients who no longer need acute care but who cannot be discharged as their onward care package is not in place.

We have been working with the CCG and our community partners CNWL to enable patients who no longer need acute care to be discharged more rapidly – as well as looking at other, innovative ways to improve the flow of patients through the hospital. This will be a top priority for us in 2015-16.

Quality is central to the care we provide here at Milton Keynes Hospital and we will continue to ensure we improve the quality of care alongside the experiences of our patients, their carers and families across the hospital.

### **Statement of Assurance**

This report has been reviewed by the Board of Milton Keynes University 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**

**Chief Executive**

May 2015

## 1.2 Introduction

This report provides an overview of the Trust's performance across our key priorities and illustrates our commitment to providing a quality service for patients.

It also outlines our planned measures for assuring and sustaining our performance for the future. This includes the recognition that there are areas which require improvement.

Milton Keynes Hospital is a district general hospital providing a broad range of general medical and surgical services, including A&E. We continue to develop our facilities to meet the needs of a fast-growing population. The hospital provides services for all medical, surgical, maternity and child health emergency admissions.

In addition to delivering general acute services, Milton Keynes Hospital increasingly provides more specialist services, including cancer, cardiology and oral surgery. It also has the responsibility for treating premature babies born locally and in the surrounding areas.

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

1. Improve Patient Safety
2. Improve Patient Experience
3. Improve Clinical Effectiveness

To support our framework for quality we have a rigorous set of standards for monitoring against local and national targets. This helps us to continually assess our performance and tackle issues as they arise. The Trust is developing our Quality Strategy. This will define the overarching priorities for the hospital in the forthcoming years. It is expected that this will be adopted by the reports to the Trust Board in Q2 of 2014/15.

As well as our staff, we are also proud of our strong relationships with our stakeholders. The involvement of patients, the public, governors, local information networks, and health system partners is integral to our development.

Our governors are involved throughout the year in monitoring and scrutinising our performance. The governors continue to demonstrate their enthusiasm and commitment to fulfilling their role as elected representatives of patients and the public, through their direct activity with the community as well as their participation in Milton Keynes Healthwatch meetings and other community forums. A Governor also attends the Quality Committee which monitors performance of the Hospital against the quality priorities set in the Quality Account.

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

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

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## Part 2

### 2.1 Priorities for Improvement

#### Introduction

The Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement.

The purpose of the 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; and
- Boards of NHS providers to report on the improvements to their services and to set out their priorities for the following year.

As part of our quality account for 2015/16 the Trust is required to choose at least 3 quality priorities for the year to be included within Part 2 of our Quality Accounts.

There are criteria for choosing these priorities which are:

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

Once agreed the quality account must report upon how progress to achieve the priorities is identified including how they will be monitored/measured and how they will be reported by the Trust.

## **2.1 Our Priorities for 2014/15**

### **Trust Objective 1 – Patient Safety**

Improvement in the collection and management of clinical observations, resulting in better management of the deteriorating patient

### **Trust Objective 2 – Patient Experience**

To achieve an improvement in the Cancer Patient Survey

### **Trust Objective 3 – Clinical Effectiveness**

To deliver the national CQUIN on Sepsis

## **Priority 1**

### **Trust Objective One – Patient Safety**

**Improvement in the collection and management of clinical observations, resulting in better management of the deteriorating patient**

The Trust has been successful in its bid for £646,000 investment into digital technology to assist in the collection of clinical observations (blood pressure, pulse, blood oxygen saturation levels). In order to utilise this programme to its full potential we are also:

- Retraining all health care and maternity support workers in taking observations and competency assessing them.
- Competency assessing all qualified nursing and midwifery staff in taking and understanding the implications of clinical observations.
- Testing the junior medical staff on their management of the deteriorating patient.
- developing our clinical observation policies and procedures to fit our new skill sets and the new technology



We have chosen this project, as during our analysis of serious incidents over the last year, our identification and management of deteriorating patients has been a reoccurring theme. We believe that by focusing on this topic we can reduce the number of clinical incidents.

We do collect data in the nursing metrics on taking clinical observations for which the target is 90%. As part of this project we will stretch this target to 95%

## Priority 2

### Trust Objective 2 – Patient Experience

**To consistently achieve a recommendation rate of 92% in the Friends and Family Test in our cancer inpatient' and outpatients' facilities and to improve the response rate to 30%.**

This year we had a very disappointing Cancer Patient Survey, with patients identifying significant improvements they felt necessary for good care. This year we have seen a growth in cancer services as a result of repatriations of patients from Northampton General Hospital, and the Trust strategy is to have its own cancer centre in the upcoming years. It is vital that we ensure that the patients within our cancer services are getting the experience and care that they deserve.

The cancer services team and the specialist teams involved in the survey have put together an action plan which they believe will deliver improvements in patient experience.

The best way to measure patient experience on an ongoing basis is to use the Friends and Family Test indicators which we collect on a monthly basis. We have poor response rates in both areas, and in order to get the best feedback from our patients to improve our services, this will be improved to 30%. Recommendation rates are not consistent, so the Trust is setting a target of 92% for Ward 22 and The Macmillan Unit and Oncology Suite.

## Priority 3

### Trust Objective 3 – Clinical Effectiveness

#### To deliver the national CQUIN on Sepsis:

- The total number of patients presenting as emergencies who met the criteria of the local sepsis protocol and were screened for sepsis
- The number of patients with sepsis and who receive intravenous antibiotics within 1 hour of presenting.

For both of the above, the targets are based upon the national CQUIN (Commissioning for Quality and Innovation) framework which has a sliding scale of achievement.

The aim in Quarter 1 is to collect the baseline data which will determine our target for improvement.

Sepsis is a common and potentially life threatening condition where the body's immune system goes into overdrive in response to an infection setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant drop in blood pressure, which can mean that the blood supply to vital organs such as the kidneys heart and brain is reduced. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS with around 35,000 deaths attributed to sepsis annually.

Problems in achieving consistent recognition and rapid treatment are thought to contribute to the number of preventable deaths from sepsis.

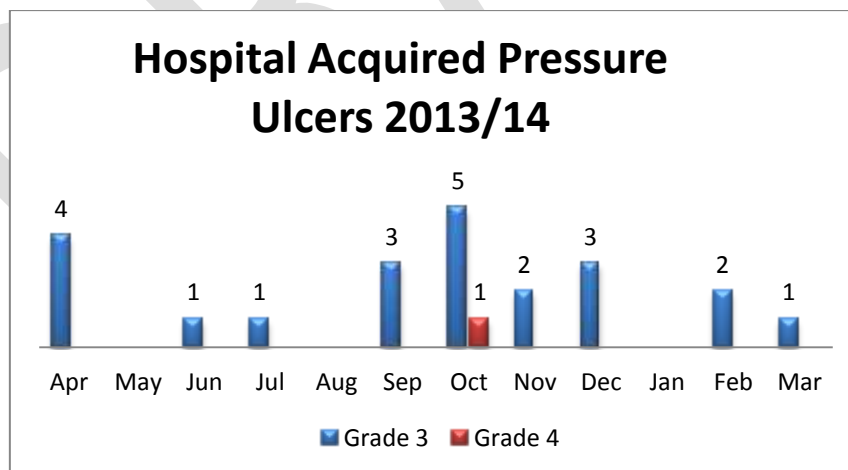
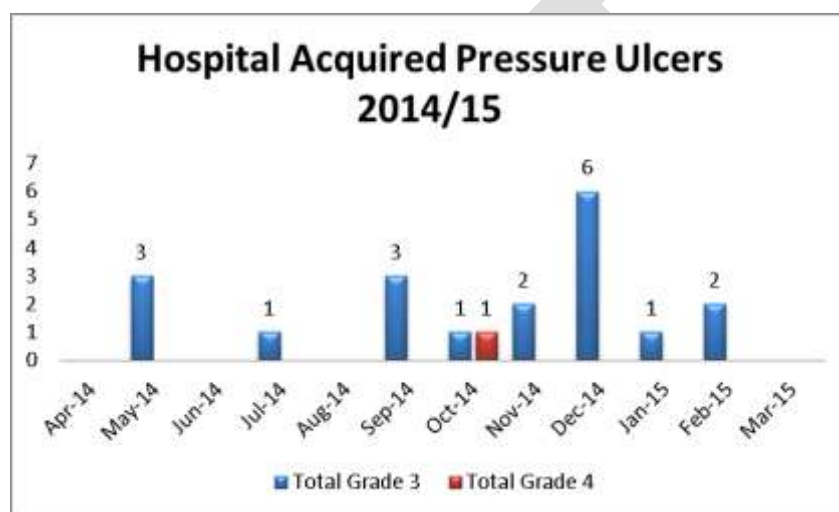
Last year the Trust undertook a significant amount of training and implemented new processes to tackle sepsis. This year by adopting the measures outlined by National Best Practice we will consolidate and develop this work further.

## How we did last year?

### Priority 1

#### Elimination of Grade 3 and 4 avoidable pressure ulcers

We did not achieve our aim to eliminate grade 3 and 4 pressure ulcers. December resulted in a large rise in the number of grade 3 pressures ulcers. This may be due to the increase number of patients who were admitted to the hospital. However we did make a very small improvement on the overall numbers compared to the previous year



Additionally, we have introduced a number of quality improvements this year that are now becoming embedded and making an impact.

These include:

- Investing in new equipment that helps reduce pressure ulcers on the heels as this is our second most common site on the body for pressure ulcer (the first being the sacrum)
- We have reviewed our education. Going forward all Registered Nurses will receive specific skills and learning via scenarios and simulation in caring for those patients who are the most frail and as such more likely to develop pressure ulcers. Our Health Care Assistants are being supported through a competency programme which prioritises pressure ulcer prevention and skin care.
- We have reviewed our We Care Round the Clock (Intentional Rounding) to include repositioning and recording at the same time.
- We have also introduced a visual prompt to remind all staff that a patient is at risk of pressure ulcers using our popular magnet system and a little red foot.
- We will be continuing to monitor pressure ulcers at Trust board level.

## Priority 2

**For all emergency admissions to be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital.**

We have stated that we saw the year as our planning year. The reason we needed such a long time to plan this project is because we know that it will involve large scale service redesign and probable investment.

Throughout 2014/15 pathways of care have been reviewed across clinical areas. These include:

- Review of the acute medical model to support rapid assessment by senior clinicians supported by the multidisciplinary teams. Patients are reviewed quickly to see if any other pathways of care may be more suitable such as Outpatient antibiotic therapy.
- The Emergency Surgical pathway has also been reviewed to help speed up assessment, diagnosis and management. This has been achieved by introducing an Advanced Nurse Practitioner and nursing team to support the introduction of 'hot

clinics' led by one consultant for outpatient review and emergency surgery being led by another.

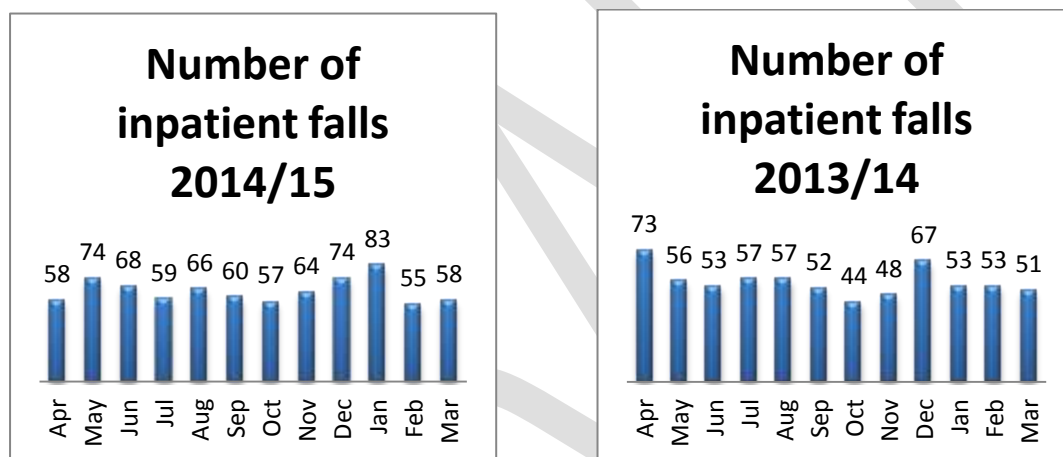
Whilst we await the outcome of the healthcare review of Bedfordshire and Milton Keynes we will be limited in our current progress of this work.

### Priority 3

#### Reduction in hospital-based falls by 5%.

Last year we set ourselves the target of reducing falls by 5% and have unfortunately fallen short of this.

The Hospital recorded 776 falls within 2014/15 compared to 664 falls within 2013/14.

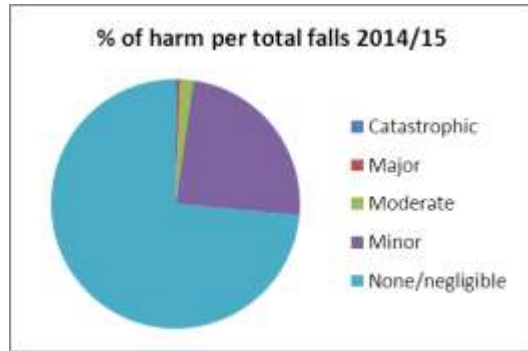
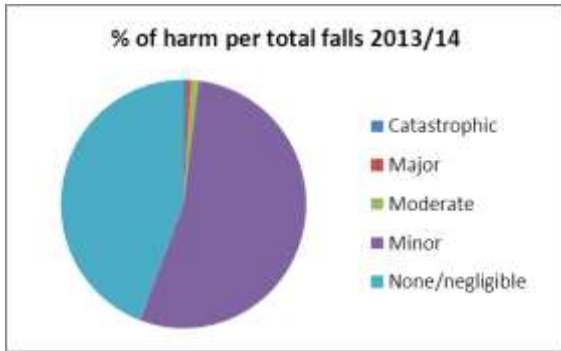


However we continue to treat more patients each year who have come in following a fall and this increases the likelihood of people falling whilst in hospital. This can be described as the rate of falls (falls per 1000 bed days).

We have also reviewed how we analyse falls. A rate of 5.6 falls per thousand bed days is seen as a key benchmark target set by the National Patient Safety Agency (NPSA)

In 2014/15 the rate was 4.85 per 1000 bed days. This is much lower than the expected rate set by the NPSA.

Measuring the harm that a fall causes is also a better indicator of how we have improved through falls prevention. Low or 'no harm' would indicate effective falls prevention as not all falls can be prevented but the impact can be reduced.



Also we are able to compare ourselves against the national average using the NHS Safety Thermometer.



In comparison to all other acute hospitals we continue to track alongside the national average in the number of falls but more significantly have a much lower level of falls with harm.

### How have we achieved this?

Falls prevention contributes to the reduction in harm when a fall occurs. For example we have embedded the assessment on admission and identification of people at risk throughout their hospital admission.

We have also introduced a new Post Falls protocol which initiates a whole team approach to reviewing why a patient has fallen to reduce the risk and harm if they are to fall again.

Patients attending our Emergency Department following a fall are now all offered referral to the Community Falls Team for ongoing support and advice.

We have reviewed our education. Going forward all Registered Nurses will receive specific skills and learning via scenarios and simulation in caring for those patients who are the most frail and as such more likely to be at risk of falls.

The most complex patients who fall are individually reviewed by the falls prevention coordinator

## **Priority 4**

### **To reduce deaths from sepsis**

#### **What is sepsis?**

Sepsis is infection that travels into the blood. Each year in the UK, it is estimated that more than 100,000 people are admitted to hospital with sepsis and around 37,000 people will die as a result of the condition.

#### **Why we chose this as a priority?**

- Sepsis is the leading cause of death in hospital worldwide (McClelland & Moxon 2014)
- The incidence of sepsis is increasing, likely in part to be due to an ageing population who are more at risk of infection
- The UK Sepsis Trust estimates over 12,500 lives per year could be saved if sepsis is recognised and treated in its early stages
- Early identification and treatment is key to reduction in death from sepsis. There is evidence to show that we can make improvements in our recognition and treatment of sepsis
- Administration of intravenous antibiotics within one hour of diagnosis of sepsis is the gold standard and priority treatment

#### **What are we have achieved this year?**

- We introduced a sepsis protocol for ED
- Continuing training and education with our medical teams based around the Sepsis Six, a tool that reminds clinicians of the 6 key actions upon recognition of sepsis.
- We are providing skills' assessment on clinical observations to all of our Healthcare Assistants to improve rapid escalation to the Registered Nurse when needed.
- We have implemented the sepsis box in the Emergency Department which has all the equipment needed for rapid treatment of a septic patient in one place.
- We have completed a baseline audit of sepsis in the emergency department so we can review the impact of the boxes.
- These are the building blocks for this year (2015/16). National CQUINs (Commissioning for Quality and Innovation) for the year ahead.

## 2.2 Statement of Assurance from the Board of directors

During 2014/15 Milton Keynes University Hospital NHS Foundation Trust provided and/or sub-contracted 36 relevant health services.

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

The income generated by the relevant health services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of relevant health services by the Milton Keynes University Hospital NHS Foundation Trust for 2014/15.

## 2.3 Participation in Clinical Audit

There were **26** national clinical audits and **4** national confidential enquiries during 2014/15 relevant to health services that Milton Keynes University Hospital NHS Foundation Trust provides.

During that period Milton Keynes University Hospital NHS Foundation Trust participated in **23 [88%]** national clinical audits and **4 [100%]** national confidential enquiries in which we were eligible to participate.

The national clinical audits and national confidential enquiries that MKUHFT participated in, for which data collection was completed during 2014/15 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.

Where available we have quoted the participation rates provided by the national clinical audits themselves. Case ascertainment may be less or more than 100% in some of these audits, depending on the method used to calculate the expected number of cases.

For national clinical audits marked by an asterisk, confirmation of percentage case ascertainment was not available from the national clinical audit provider in time for publication but we believe our contribution for these audits to be 100%.



Eligible Quality Account Audit 2014-15	Category	Participated	% of cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Heart	Yes	75%
Adult Community Acquired Pneumonia	Acute	Yes	*100%
Bowel cancer (NBOCAP)	Cancer	Yes	*100%
Cardiac Rhythm Management (CRM)	Heart	Yes	100%
Case Mix Programme (CMP)	Acute	Yes	*100%
Diabetes (Adult)	Long term conditions	Yes	*100%
Diabetes (Paediatric) (NPDA)	Long term conditions	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Older People	Yes	100%
Inflammatory Bowel Disease (IBD) programme	Long term conditions	Yes	*100%
Lung cancer (NLCA)	Cancer	Yes	*100%
Major Trauma: The Trauma Audit & Research Network (TARN)	Acute	Yes	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Women's & Children's Health	Yes	100%
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Acute	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Long term conditions	Yes	*100%
National Comparative Audit of Blood Transfusion programme	Blood and Transplant	Yes	*100%
National Emergency Laparotomy Audit (NELA)	Acute	Yes	134 cases 39%
National Joint Registry (NJR)	Acute	Yes	*100%
National Prostate Cancer Audit	Cancer	Yes	*100%
Neonatal Intensive and Special Care (NNAP)	Women's & Children's Health	Yes	100%
Non-Invasive Ventilation – adults	Acute	Yes	*100%
Oesophago-gastric cancer (NAOGC)	Cancer	Yes	*100%
Rheumatoid and Early Inflammatory Arthritis	Long term conditions	Yes	*100%
Sentinel Stroke National Audit Programme (SSNAP)	Older People	Yes	*100%

NCEPOD Study Eligible 2014-15	Participated	Cases Submitted
Sepsis	Yes	5
Gastrointestinal Haemorrhage	Yes	2
Lower limb amputation	Yes	6
Tracheostomy NCEPOD Study	Yes	7

### Review of Clinical Audits

The reports of 4 national clinical audits were reviewed by the provider in 2014/15 and MKHFT intends to take the following actions to improve the quality of healthcare provided have been put in place. For example:

National Clinical Audit	Actions to improve quality of care
National Hip Fracture Database	<ul style="list-style-type: none"> <li>• Total Hip Replacement for #NOF eligibility criteria and compliance at Milton Keynes</li> <li>• Non-operative management for un-displaced intracapsular #NOF's</li> </ul> <p>In comparison to the year before improvements have been shown and the Trust expect this year's report to show further improvement.</p> <p>Currently we are working with hip fracture patients to reduce hospital acquired infections by introducing a range of interventions specific to hip fracture care, which will be audited and presented during 2015/16.</p>
National Paediatrics Asthma Audit	<ul style="list-style-type: none"> <li>• Staff education on best practice</li> <li>• Discharge labels to be used in patient notes for easy reference of discharge checklist for asthma</li> <li>• Staff Education- advice on smoking cessation to parents by doctors and nurses</li> <li>• Staff Education- shared learning with audit findings to Emergency Department staff</li> </ul>
National Sentinel Stroke audit	<ul style="list-style-type: none"> <li>• Advanced nurse practitioner has been appointed to facilitate rapid admission to the stroke unit.</li> <li>• Process for fast track bed procedure agreed with consultants.</li> <li>• Stroke patients on outlier wards to be discussed at 10am operational bed meeting/ safety huddle</li> <li>• SRU staff received swallows training as part of the recent Bedford University</li> </ul>

	<p>Stroke Nurse training package.</p> <ul style="list-style-type: none"> <li>● Review of each patient who fails to receive a screen in 24 hours – results to be shared at MDT meeting.</li> <li>● Benchmarking has been undertaken and has identified a need for additional OT therapist support for SRU.</li> <li>● Uplift in physiotherapy staff has facilitated weekend working.</li> <li>● Benchmarking has been undertaken and has identified a need for additional SALT support for SRU.</li> <li>● SALT to attend weekly MDT meetings</li> <li>● Ring fence two fast track beds to facilitate rapid admission from ED.</li> <li>● Clear guidelines for junior medical staff.</li> <li>● Each patient failing to meet the 48 hour target now has a clinical consultant review to identify the reason for failure - results to be shared at MDT meeting.</li> <li>● Implementation of Monday MDT board round to complement full Thursday MDT</li> <li>● All stroke patients on outlier wards to be discussed at MDT meeting and an MDT goals form completed and placed in patients notes.</li> <li>● Ensure Trust care planning/ discharge document is completed.</li> <li>● All patients requiring repatriation are discussed at the daily 10am operational bed meetings.</li> <li>● Work with bed management team to step down medical patients from SRU to facilitate rapid admission for stroke patients.</li> <li>● Raise profile of stroke service within ED</li> <li>● Provide education for junior doctors in ED.</li> <li>● Teaching session from Stroke Lead at Grand round.</li> </ul>
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The reports of 41 local clinical audits were reviewed by the provider in 2014/15 and Milton Keynes University Hospital NHS Foundation Trust intends to take the following actions to improve the quality of health. For example:

Local Clinical Audit	Actions to improve quality of care
Cardiac Rhythm Management	<ul style="list-style-type: none"> <li>● Files to be checked against the CRS system to provide comparison against SPINE</li> <li>● Trial checking all cancelled ICD/Pacemaker appointments to identify RIP's</li> <li>● Continue to follow department protocols for persistent DNAs</li> <li>● Continue to follow department protocols for home visits</li> </ul>
Sepsis – diagnosis and management	<ul style="list-style-type: none"> <li>● Screen everyone who attends</li> <li>● Use the proforma</li> <li>● Administer treatment within the first hour from arrival</li> <li>● Antibiotics have the best evidence – if you only do one thing, give antibiotics!</li> <li>● Every hour's delay increases mortality by 7.6%</li> </ul>

<p>Patient outcome following anaesthetic review</p>	<ul style="list-style-type: none"> <li>● Disseminate audit findings to Pre Assessment Team and Anaesthetic Team.</li> <li>● As a result of this audit a new referral has been developed and is in circulation. To review the new anaesthetic referral form on an ad hoc basis to determine if compliance is being achieved by the POA nurses and the anaesthetists</li> <li>● Changing the patients' pathway by combining the stand alone (patient's pathway) document with the anaesthetic referral. To place anaesthetic review sheets with pathway, to ensure all information is in one place for TCI</li> <li>● Patients who have an anaesthetic assessment – to ensure that proformas have this documented by POA and the hubs are entering this onto the TCI list. the anaesthetists on the day are then alerted about the high risk patients on their list</li> <li>● To increase the number of patients that can be telephone assessed by the anaesthetic team.</li> <li>● To look at potential one POA nurse running a sole clinic for patients to have dual and anaesthetic clinic – to support communication and quality of care</li> <li>● A new EDM template for the orthopaedic clinic as part of the Rapid Recovery project, is currently being developed for routine procedures so that patients can be removed from the waiting lists if they are not fit for surgery – looking at a specific criteria</li> </ul>
<p>Pressure ulcer assessment preventative care and outcomes</p>	<ul style="list-style-type: none"> <li>● Tissue Viability Nurses undertake twice weekly Pressure Ulcer Prevention Rounding on Wards 15 16 17 and 18 with feedback to matrons contemporaneously</li> <li>● Involve Physiotherapy and Occupational Therapy teams in proactive prevention; for example, chair height adjustments</li> <li>● All inpatients to be repositioned (or encouraged to move themselves at intentional rounding times)</li> <li>● Daily RN skin check of all patients</li> <li>● Introduce new visual prompt (red foot)to all areas to identify patients at risk of developing or who have pressure ulcers (Magnets, logo etc to aid with increasing awareness and campaign)</li> <li>● Pilot use of alarm system to remind staff to put patients back to bed to support the " No more than 2 hours in the chair" recommendation</li> <li>● Introduce new Foot mats to all clinical areas to reduce heel sores with appropriate education</li> <li>● Repeat ward based product demos by reps for Aderma pads, Repose boots etc.</li> <li>● Repeat AES stocking training on ward for sizing &amp; fitting and care</li> </ul>

## 2.4 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Milton Keynes University Hospital NHS Foundation Trust in 2014/15, who were recruited to participate in National Institute of Health Research studies approved by a research ethics committee was 3,139, with some data left to be reported. Our target for the year was 500 patients.

41 studies in total have contributed to this recruitment figure. This year we have given NHS permission for a further 19 portfolio studies as well as a number of PICs and non-portfolio Research projects.

The Research and Development department had a budget of £500,000 for 2014/15, which has been used to provide research and development staff to support portfolio studies across the Trust. This not only includes research nurses but also the support services that are an integral part of the research process: pathology, pharmacy and radiology. This year we have recruited to a number of new posts and increased the team significantly. The team now includes: two paediatric Research Nurses, a Research Midwife, Rheumatology Research Nurse and a Sexual Health Research Nurse. We have also increased the number of R&D support staff to include an Academic Research Coordinator, an additional Research Coordinator and a Cancer Data Officer. Extra funding from the Cancer Research Network when it disbanded allowed 2 x 0.75 wte Clinical Lead posts, one for Haematology and one for Oncology.

Cancer CQUIN: to increase the percentage of patients enrolled in clinical trials by 35%. Our target was to recruit 143 patients into Cancer Trials this year and we have recruited 158 patients, exceeding the target.

Our aim is to provide patients with the latest medical treatments and devices and offer them an additional choice where their treatment is concerned. These are just a few examples of the National Institute of Health Research portfolio studies that we have recruited to this year:

**Persephone: Duration of Trastuzumab with Chemotherapy in Patients with Early Breast Cancer: Six Months versus Twelve.** This is a multi-centre study within the UK and has been designed to investigate the A phase III, randomised trial comparing 6 months (9 cycles) trastuzumab treatment with 12 months (18 cycles), in patients with HER2 positive early breast cancer, in terms of efficacy (disease-free and overall survival), cost-effectiveness (Health Resource Use and Quality of Life) and safety (cardiac and other toxicity). We have recruited 6 patients so far to this study.

**The SIMS Trial: Adjustable Anchored Single-Incision Mini-Slings Versus Standard Tension-Free Mid-Urethral Slings in the Surgical Management Of Female Stress Urinary Incontinence; A Pragmatic Multicentre Non-Inferiority Randomised Controlled Trial.** This study aims to assess whether adjustable anchored single-incision mini-slings are associated with non-inferior cure rates, less postoperative pain, shorter hospital stay, earlier recovery, earlier return to work and are whether they are more cost effective than standard tension

free mid-urethral slings in surgical management of female stress urinary incontinence. We have recruited 15 patients so far into this study.

**DARE: Diabetes Alliance for Research in England.** This study is investigating the inherited and environmental causes of diabetes. We have recruited 105 patients to this study this year alone.

### **Raising the Profile of R&D and developing 'Home Grown' Research**

This year we have worked to raise the portfolio of R&D within the Trust. We held stands in main outpatients and the Eaglestone restaurant for both patients and staff as part of International Clinical Trials Day and supported the 'OK to ask' campaign, which aimed to increase awareness of trials in the general public and tell them it is OK to ask your clinician about any studies that may be open to you.

In December we held our second Research Awareness Seminar which was well attended by clinicians in our Trust, academics from our local universities, staff from the Thames valley and South Midlands Clinical Research Network and Oxford Academic Health Science Network. This stimulating event featured talks from representatives working for Medical Detection Dogs along with an excellent demonstration by Jack, a working cocker spaniel who expertly detected cancerous samples using his sense of smell. This served as an excellent networking opportunity and as a result more clinicians within MKUHFT are designing own account research.

We have continued to hold monthly Research Collaboration Meetings which are attended by colleagues from Buckingham University and the Open University along with our own research active clinicians and research staff. We meet to discuss new collaborative ideas, grant opportunities and provide expertise to help push forward own account research.

There have been 23 ideas from MKUHFT staff and/or University academics, 17 of which are still ongoing and actively progressing. Two MKUHFT sponsored studies were developed to a stage where they were ready to submit for ethical approval (both in collaboration with The Open University):

- Exploring the use of activity monitors with young people with Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) Pilot Study - (Approved 2nd April 2015)
- Studying the activity levels of patients recovering from knee surgery – (Approved 16th April 2015)

A submission has been made to Medical Research Council for £100k grant to fund a clinical trial of investigational medicinal product (CTIMP) looking at nursing fluorescence dye to detect the spread of cancer to lymph nodes during surgery, therefore potentially reducing the number of patients recalled for further surgery. This is in collaboration with The Open University with consultant surgeon as the Chief Investigator and MKUHFT as the Sponsor.

We have worked closely with consultant urologist and Medical Detection Dogs to develop a protocol and supporting documents which will be submitted to ethics for approval imminently.

We are working on some areas in direct relation to funding calls put out by the National Institute for Health Research. These areas include HIV and Sexual Health and End of Life care. We also have active working groups refining ideas for research projects in Diabetes, Ageing and Frailty, Cardiology, Paediatrics and Trauma and Orthopaedics.

## 2.5 Goals agreed with Commissioners CQUIN

The CQUIN (Commissioning for Quality and Innovation) framework is a national framework for nationally and locally agreed quality improvement schemes. The Framework is worth 2.5% of MKUHs National / Specialist contracts; £3.6m.

For the year 2014/15 the Trust has delivered approximately £1.9m out of the total potential £3.6m, but this has yet to be verified officially with the Commissioners.

The CQUINs and the performance in each are tabled below:

<b>2014/15 CQUINs for MKUH</b>			
<b>Goal</b>	<b>Goal Name</b>	<b>High level detail</b>	<b>Performance 2014/15</b>
1	Friends and Family Test (FFT)	Implement Staff FFT Implement FFT into Day case and Outpatient areas. Increase the response rate for Inpatients and A&E Reduce Negative responses	The Trust achieved 3 out of the 5 elements (implementing FFT into Day case, Outpatients and Staff, and reducing negative responses).
2	NHS Safety Thermometer	A monthly prevalence data report on Pressure Ulcers, Falls, Urinary Tract Infection associated with catheters and Venous Thromboembolism (Assessment and Prophylaxis) To reduce pressure ulcers by 50%	The Trust attended all required pressure ulcer meetings and therefore secured 50% of this CQUIN. The Trust did not achieve the required reduction in pressure ulcers.
3	Dementia	90% success in screening patients for risks of dementia and ensuring appropriate onward referral for management. Provision of leadership, training and knowing how well supported carers of people with dementia feel.	The Trust has achieved all 3 elements of the CQUIN this year.

Goal	Goal Name	High level detail	Performance 2014/15
4	Improved Discharge Planning	Increasing the number of patients discharged before 12 Midday and increasing the number of patients who have an EDD recorded within 24 hours of admission	The Trust achieved two of the targets for increased discharge before 12, securing 50% of that CQUIN. The Trust achieved 30% of the EDD CQUIN.
5	Respiratory Care Bundle	Providing AECOP patients, where suitable with a discharge care bundle to support early discharge and reduce readmission.	The Trust achieved 75% of this CQUIN, only falling short in quarter four of the required audit target.
6	Medicine Related safety incidents	Increase the number of reports logged for medication related safety incidents.	The Trust exceeded the required target for this CQUIN.
7	Frail Elderly Ward Moves	Reduce the total number of ward moves during an episode of care for patients over 75 years old, with no moves being made between 10pm and 7am.	The Trust was unable to achieve this target for any month this year.
8	Reduction in Falls	Reduce the number of inpatient falls to equal to or less than 53 per month.	The Trust was unable to achieve this target for any month this year.
9	Stroke 4 Hour Transfer	Achieve 95% of Stroke patients being transferred up to the Stroke Unit within 4 hours of admission each month.	The Trust was unable to achieve this target for any month this year.
10	HIV	90% of patients recorded under the HIV service must be registered and disclosed to their GP	The Trust achieved 75% of this CQUIN, dropping short of the 90% target for 3 months of the year.
11	Increasing Cancer Trials	Increase the number of patients recruited to cancer trials.	The Trust exceeded the required target of patients recruited to Trials.



## 2.6 Care Quality Commission (CQC) registration and compliance

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

- Urgent and Emergency Services
- Medical Care
- Surgery
- Critical Care
- Maternity and Gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Milton Keynes University Hospital NHS Foundation Trust has no conditions on its registration.

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

The Trust had a planned inspection from the CQC the week commencing 21<sup>st</sup> October with CQC inspectors on site for 2 days. The overall rating for the Trust following inspection was 'requires improvement'. However it should be noted that the overall matrix identifies many areas where 'Good' was accredited with one example of 'Outstanding' for Surgery under the well led category (see matrix below). Outpatients and Diagnostic imaging were not rated for the effective category which is standard CQC practice for this type of organisation.

Specialty Area	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency services	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Good	Good	Good	Good	Outstanding	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and Gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of Life Care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and Diagnostic Imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

## **Key findings from the report**

1. Staff were caring and compassionate, treating patients with dignity and respect
2. The Trust was generally clean and well-maintained
3. Infection rates were in line with national averages. Staff washed their hands between patients
4. The Trust had consistently not met the target for treating 95% of patients attending A&E within four hours. Plans were in place to address this. Demand was exceeding the capacity
5. There were staff vacancies in some areas and some staff felt under pressure, but plans were in place to address this
6. No open mortality outliers at the Trust, outcomes for patients were generally good
7. Patients were given assistance to eat and drink, although fluid and intake charts were not always completed. Catering department worked closely with wards nurses and dieticians.

## **Areas of outstanding practice**

1. Sensory walk rounds
2. The Cancer Patient Partnership Group
3. Staff working in bereavement teams
4. Leadership within surgery was “outstanding”
5. Consultant medical staff were extremely engaged with leaders in the Trust

## **Areas for improvement**

1. Calling for urgent help in the MAU waiting area
2. Secure storing of cytotoxic waste
3. Full and accurate records relating to care and treatment (VTE, dementia, fluid balance)
4. Staff uptake of mandatory training
5. Transferring inpatients from MAU within 72 hours
6. Pre-operative safety checks
7. Cleaning schedules for equipment such as shower chairs and stools
8. Privacy and dignity in A&E
9. DNACPR documentation
10. Completion of action plans within maternity and gynaecology
11. Operational protocols for partners on Ward 9 overnight.

Action plans have been developed by the Trust to drive improvement with aims and objectives set at continuing to build on the good. The Trust have ambitions to achieve outstanding and continuing our journey to excellence.

## 2.7 Data Quality

Milton Keynes University Hospital NHS Foundation Trust submitted records during 2012/13 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:

99.7% for admitted patient care;

99.8% for outpatient care; and

98.2% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was:

100.0% for admitted patient care;

100.0% for outpatient care; and

100.0% for accident and emergency care.

Milton Keynes University Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2014/15 was 84% and was graded Green.

Milton Keynes University Hospital NHS Foundation Trust was not selected for an external Payment by Results Audit of clinical coding during the financial year 2014-15.

Milton Keynes University Hospital NHS Foundation Trust Information Governance Audit of clinical coding achieved the following scores for overall accuracy:

- 90% of primary diagnosis correctly coded
- 90.8% of secondary diagnosis correctly coded
- 94.66% of primary procedures correctly coded
- 96.01% of secondary procedures correctly coded

The number of episodes in the sample with errors which would have resulted in a change to the Healthcare Resource Group HRG was 16 which represent 8% of the total cases.

The commissioner was overcharged by £5736 for the errors in the audit sample.

## 2.8 Reporting against core indicators

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

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

- a) the national average for the same; and
- b) with those NHS Trusts and NHS foundation Trusts with the highest and lowest of the same, for the reporting period.

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

Domain 1 Preventing people from dying prematurely				
Domains of Quality	Level	2012/13	2013/14	2014/15
Summary Hospital-Level Mortality Indicator (SHMI) value and banding	MKUHFT	1.0043 Band 2	1.04 Band 2	0.94 Band 2
	National	1.00	1.00	1.00
	High /Low	0.68-1.21	0.63-1.16	0.54-1.19
% of admitted patients whose treatment included palliative care	MKUHFT	1.06%	1.20%	1.20%
	National	Not yet available	1.19%	1.34%
	High /Low	Not yet available	0-3.2%	0%-3.1%
% of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care	MKUHFT	Not yet available	27.5%	30.8%
	National	Not yet available	20.6%	24.7%
	High /Low	Not yet available	0-44.1%	0-49%

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

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality. Banding 2 means that the mortality rate is 'as expected'

Our priorities this year continue to focus on improving this result as they include management of sepsis and the early recognition of the deteriorating patient.

### **Indicator 2: % of admitted patients whose treatment included palliative care**

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality.

### **Indicator 3: % of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care**

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality.

Domain 3 Helping people recover from episodes of ill health or following injury				
*Patient Reported Outcome Measures for:	* Patient Reported Outcome Measures are retrospective reported measures and as such data for 12/13 is not yet available			
Domains of Quality	Level	2012/13	2013/14	2014/15
Groin hernia surgery	MKUHFT	0.08	Insufficient data	Insufficient data
	National	0.08		
	High /Low	0.014-0.138		
Varicose veins surgery	MKUHFT	N/A	Insufficient data	Insufficient data
	National	0.09		
	High /Low	0.015-0.189		
Hip replacement surgery	MKUHFT	0.45	Insufficient data	Insufficient data
	National	0.42		
	High /Low	0.346-0.503		
Knee replacement surgery	MKUHFT	0.3	Insufficient data	Insufficient data
	National	0.31		
	High /Low	0.198-0.384		
Emergency Readmissions to hospital within 30 days standardised percent	MKUHFT	7.60%		
	National small acute	Not yet available		
	High /Low	Not yet available		
Emergency Readmissions to hospital within 28 days 0-15yrs standardised percent <small>Changed in 2013/14 to 28 days split 0-16 and 16+ To be completed after year end</small>	MKUHFT		12.71%	Awaiting
	National small acute		9.87%	Awaiting
	High /Low		0-14.87%	Awaiting

Emergency Readmissions to hospital within 28 days >16yrs standardised percent	MKUHFT		11.91%	Awaiting
	National small acute		11.07	Awaiting
	High /Low		0-12.69	Awaiting

### What are PROMS - Patient Reported Outcome Measures?

The NHS is asking patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This will help the NHS measure and improve the quality of its care.

#### Indicator 4: PROM scores groin hernia surgery;

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by awaiting the availability of a second data set on which actions may be taken if required.

The response rate of post-operative questionnaires returned is low despite a high response rate of pre-operative. Therefore there is not enough data on which to base effective analysis and is not published. Increasing patient engagement in the provision of this feedback is required.

#### Indicator 5: PROM scores varicose veins surgery;

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by awaiting the availability of a second data set on which actions may be taken if required.

The response rate of post-operative questionnaires returned is low despite a high response rate of pre-operative. Therefore there is not enough data on which to base effective analysis and is not published. Increasing patient engagement in the provision of this feedback is required.

#### **Indicator 6: PROM scores hip replacement surgery;**

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by awaiting the availability of a second data set on which actions may be taken if required.

The response rate of post-operative questionnaires returned is low despite a high response rate of pre-operative. Therefore there is not enough data on which to base effective analysis and is not published. Increasing patient engagement in the provision of this feedback is required.

#### **Indicator 7: PROM scores knee replacement surgery**

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by awaiting the availability of a second data set on which actions may be taken if required.

The response rate of post-operative questionnaires returned is low despite a high response rate of pre-operative. Therefore there is not enough data on which to base effective analysis and is not published. Increasing patient engagement in the provision of this feedback is required.

#### **Indicator 8: Emergency Readmissions to hospital within 28 days** (This was changed by the National Information Centre in 2013/14 to 28 days from 30 days readmissions and is retrospective data to 2012/13)

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by continuing to review why patients are readmitted and working with our partners within the community health services and local social care teams in making changes to reduce readmissions.



Domain 4 Ensuring people have a positive experience of care				
Domains of Quality	Level	2012/13	2013/14	2014/15
Responsiveness to inpatients personal needs	MKUHFT	63.7		65.3
	National	68.1		68.7
	High /Low	57.4-84.4		54.4-84.2
% of staff who would recommend the provider to friends or family needing care  High is better	MKUHFT	50%	59%	61%
	National	65%	66%	59%
	High /Low	35-94%	40-94%	35-84.2%

#### **Indicator 9: Responsiveness to inpatient personal needs**

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by ensuring that all the clinical divisions have reviewed the results of the inpatient survey and work together to develop actions. Although there has been a slight improvement in the score specific actions are being taken to address what our patients are telling us about their experiences of care. These will be monitored through the trust performance review processes.

#### **Indicator 10: % of staff who would recommend the provider to friends or family needing care**

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services by, continuing to ensure staff feel supported and that their feedback is heard and responded to. Staff have a number of ways of giving feedback, face to face and anonymously. Weekly messages from the Chief Executive also include individual accolades received and achievements by teams.

Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm				
Domains of Quality	Level	2012/13	2013/14	2014/15
% of admitted patients risk assessed for VTE High is better	MKUHFT	96	96%	*96%
	National	94.1	96%	*96%
	High /Low	10 - 84.6	75-100%	*74-100%
Rate of C difficile per 100,000 bed days Low is better	MKUHFT	13.36	13.7	28.3
	National	Not yet available	17.3	25
	High /Low	Not yet available	0-30.7	8.4-49.0
Total patient safety incidents	MKUHFT	2850	2796	1856
Rate of patient safety incidents per 100 admissions From April 2014 - Rate per 1,000 bed days	MKUHFT	4.55	4.5	*24.33
	National (Small Acute)	6.79	6.4	*35.89
	High /Low	*3.48-17.64	*3.48-17.64	*0.24-74.96
Total patient safety incidents resulting in severe harm or death	Total Number MKUHFT	19	21	6
Rate patient safety incidents resulting in severe harm or death	% MKUHFT	*0.1%	0.1	*0.3
	National (Small Acute)	0.90%	0.1	*0.9
	High /Low	0.1 - 2.4%	0-0.4	*0-74.3

\*Based upon data available at time of report

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

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by continuing to provide more support in data collection to ensure that the assessment completed in health records are recorded for the measure. This continues to be monitored monthly.

### **Indicator 12: Rate of C difficile**

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by continuing to review each case and where there have been agreed lapses in care this is reported to the trust board and commissioners.

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

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

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality as we are below the national average for this indicator.

## Part 3 Other Information

### Review of Quality 2014/15

In selecting our quality metrics for the quality overview we have chosen measures from the Trust Board scorecard which forms part of our continuous Trust review and reporting. These measures cover patient safety, experience and clinical outcomes. They are metrics that are nationally known to be important indicators in their respective areas, as well as those which reflect our quality priorities. Where possible we have included historical performance and where available we have included national benchmarks. Some of the measures have changed over time and as such information regarding these changes is included.

PATIENT SAFETY				
Indicator	Measurement used	2012/13	2013/14	2014/15
<b>Hand hygiene compliance</b>	Internal target – percentage compliance as measured by hand hygiene measured by exception to compliance	89.50%	93.8%	87.95%
<b>Hospital-acquired pressure ulcers (Grades 3 and 4)</b>	Internal target – total number recorded on Datix and investigated through Serious Incident framework (electronic incident reporting system)	6 Grade 3 only	23 Grade 3 1 Grade 4	23 Grade 3 1x Grade 4 (4 x Grade 3 downgraded)
<b>Patient falls</b>	Internal target – total number of reported incidents.	669	668	776
<b>Medication incidents</b>	Internal target – total number of reported incidents.	386	380	713
<b>Serious incidents</b>	Internal target – total number of reported incidents.	101	125	125
<b>"Never" events</b>	This is based on a nationally accepted list of events published by the National Patient Safety Agency.	2	0	1

## **Hand hygiene compliance**

Ensuring that all hospital staff clean their hands between patients has contributed towards a reduction in health care associated infections across the NHS.

The data collection tool was reviewed last year to better reflect the World Health Organisation's five moments of hand hygiene and added in the Bare below the Elbow standard. There are 37 areas that complete the audit and those that do not return the audit are considered to be lapse in the standards and are written to by the Chief Nurse. The Infection Prevention Control Team and clinical teams will continue to promote the importance of effective hand hygiene and Bare below the Elbow.

## **Hospital-acquired pressure ulcers (Grades 3 and 4) and Serious Incidents**

All Grade 3 and 4 pressure ulcers are reported as a Serious Incidents. Pressure ulcers are reported at the time of the incident. However the root cause analysis of four of the Grade 3 pressure ulcers reported, were found by our commissioners to have had all preventative care provided and the pressure ulcer could not be avoided.

Pressure ulcer prevention has been a quality priority for 2014/15 and will continue to be a key indicator of quality and ongoing improvement action for the year ahead.

## **Patient Falls**

As described in Part 1 the number of falls has increased but against an increase in the number of patients being treated. However we have seen a significant reduction in the number of falls where harm has occurred that shows that our training and falls prevention care is having an impact.

Falls prevention will continue to be a key indicator of quality and will continue to be monitored and reviewed.

## **Medication incidents**

Medication incidents are reported onto our incident reporting system when errors have been made. An error is reported even if no harm has been caused to a patient. Errors can be about prescribing, giving (known as administering) or dispensing (when the pharmacy department issues medications). Reporting medication incidents is the right thing to do and investigations into incidents often provide all staff with learning and sharing of improvements in practice.

As a hospital we had a low number of incidents reported compared to what is expected based upon the number and types of patients we care for. As such this year as one of our local CQUINs there has been a focus on increasing the reporting of medication incidences; led by our pharmacists we have seen a significant increase which was the intended outcome and will contribute towards learning and improvements for the year ahead.

## Never Events

There are over 20 listed never events listed by the National Patient Safety Agency (NPSA 2014/15). They are selected as they are considered to be incidents that should not happen.

We have had 1 never event this year. As a never event, a comprehensive root cause analysis has been completed. All outcomes and lessons learnt in the investigation has been shared with the patient affected, all staff involved in the incident and shared across the trust in order to prevent it happening again. We are currently implementing an action plan.

CLINICAL EFFECTIVENESS				
Indicator	Measurement used	2012-13	2013-14	2014-15
<b>Hospital standardised mortality ratio (HSMR): all</b>	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	106.6	88.1	90.0
<b>Perinatal death rate</b>	This data is provided to the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries)	Perinatal rate 6.5 per 1,000	Perinatal rate 7.8 per 1,000	Awaiting data
<b>Still birth rate</b>		Stillbirth 5.7 per 1,000	Stillbirth 5.7 per 1,000	Stillbirth 2.1 per 1,000
<b>Readmissions under 30 days (elective)</b>	Emergency admissions within 30 days of elective discharge, including day cases. Internally set target	12.4	2.8%	2.6%
<b>Readmissions under 30 days (non-elective)</b>	Emergency admissions within 30 days of non-elective discharge, including day cases. Internally set target	2.6	13.4%	12.2%

## Hospital standardised mortality ratio (HSMR)

To understand the peak in 2012/13 a case note analysis and improvement actions were undertaken. We have significantly improved but want to continue this progress which is why we selected improving sepsis care as one of our priorities for 2014/15 as the analysis found that sepsis was an area that required improvement.

## Perinatal and still birth rate

Awaiting data

PATIENT EXPERIENCE				
Indicator	Measurement used	2012-13	2013-14	2014-15
<b>Informal complaints from patients</b>	The number of informal complaints from patients received by the Trust	443	269	NA
<b>Complaints</b> 2014/15 change of classification to includes all PALs and verbal complaints in overall number	The number of formal (written) complaints from patients received by the Trust	295	175	609
<b>Midwife : birth ratio</b>	Birth Rate Plus Midwifery Workforce planning tool	30	1 to 29	30

<b>WORKFORCE</b>				
<b>Indicator</b>	<b>Measurement used</b>	<b>2012-13</b>	<b>2013-14</b>	<b>2014-15</b>
<b>Staffing level incidents</b>	Internal target – total number of reported incidents	174	218	503
<b>Incidents of violence towards staff</b>	Internal target – total number of reported incidents	29	56	55

### Staffing level incidents

Reporting of staffing level incidents was changed in the last year. There used to be a staffing sub-category, however it was recognised that staffing is a contributory factor rather than an incident and therefore the category was removed and staffing incidents are now picked up where 'insufficient staffing' is recognised as contributory to any incident.

<b>Performance against key national priorities and regulatory requirements 2010 to 2014</b>				
<b>Indicator</b>	<b>Target and source (internal /regulatory /other)</b>	<b>2012-13</b>	<b>2013-14</b>	<b>2014-15</b>
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	>96% set by Monitor	Achieved 97.8%	Achieved 97.7%	Achieved 98%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	>85% set by Monitor	Achieved 87.84%	Achieved 99.1%	Achieved 86.8%
Maximum wait of 2 weeks from GP referral to date first seen for all cancers	>93% set by Monitor	Achieved 96.8%	Achieved 96.7%	Achieved 94.9%
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments	>98% set by Monitor	Achieved 100%	Achieved 100%	Achieved 100%
Maximum waiting time of 31 days for subsequent cancer treatments: surgery	>94% set by Monitor	Achieved 98.6%	Achieved 97.2%	Achieved 100%



Indicator	Target and source (internal /regulatory /other)	2012-13	2013-14	2014-15
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients	>93%	Achieved 95.9%	Achieved 94.6%	Achieved 96.1%
Referral to treatment within 18 weeks: Admitted	Admitted: >90%	Achieved 91% 15 out of 19 specialties are above 90% or have no patients recorded	Not achieved 88.8% 10 out of 13 specialties are above 90%	Achieved 90.1% 10 out of 13 specialties above 90%
Referral to treatment within 18 weeks: Specialty	Specialty: set by Monitor and Care Quality Commission; cannot under-achieve >3/18	As above	As above	As above
Patient on incomplete pathway	Patient on an incomplete pathway: 92%	Achieved 95.4%	Achieved 94.8%	Achieved 94.9%
A&E treatment within 4 hours (including Walk-In Centre)	>95% Set by Monitor and Care Quality Commission	Achieved 91.7%	Not achieved 94.4%	Not achieved 91.6%
Rapid Access Chest Pain Clinic % seen within 2 weeks	100% Set by Care Quality Commission	Achieved 100%	Achieved 100%	Achieved 100%
Cancelled operations: %age readmitted within 28 days	>95%	Achieved 95%	Not achieved 90.8%	Not achieved 99.6%
Clostridium difficile infections in the Trust <small>*change reporting to reflect lapses care 2014/15</small>	Set by DH /SHA	Not achieved 19 Against 14	Not achieved 37 against 13	5 agreed lapses in care against 19
MRSA bacteraemia (in Trust)	Zero tolerance set by DH	0	Not Achieved 3 against 0	0
MRSA bacteraemia (across Milton Keynes total health economy)	Zero tolerance set by DH	0	6	3

**ANNEX 1 – Statements from NHS: Milton Keynes, Milton Keynes LINK and Milton Keynes Council’s Health and Adult Social Care Select Committee**  
(including explanation of changes to final version of QA after receiving the statements)

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## **ANNEX 2 –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 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 incorporate the above legal requirements) and on the arrangements that NHS 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 2014/15;
- 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 2014 to May 2015
  - Papers relating to Quality reported to the Board over the period April 2014 to June 2015
  - Feedback from the commissioners dated xx/xx/xxxx
  - Feedback from governors on quality priorities dated xx/xx/xxxx
  - Feedback from Local Healthwatch organisations dated xx/xx/xxxx
  - The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xx/xx/xxxx
  - The national patient survey xx/xx/xxxx
  - The national staff survey xx/xx/xxxx
  - The head of Internal audit’s annual opinion over the Trust’s control environment dated xx/xx/xxxx
- CQC quality and risk profiles dated xx/xx/xxxx
- 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;
- 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](http://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](http://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

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

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

## Annex 3: Independent Auditor's report

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## **Annex 4: Feedback on the Quality Account**

If you would like further information contained within this report, please write to

**Michelle Evans-Riches, Trust Secretary**

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

Or email her at: [michelle.evans-riches@mkhospital.nhs.uk](mailto:michelle.evans-riches@mkhospital.nhs.uk)

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