Milton Keynes University Hospital NHS Foundation Trust

Milton Keynes Hospital

Quality Report

Standing Way
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Good
Medical care (including older people's care)	Good
Maternity and gynaecology	Good
End of life care	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Milton Keynes University Hospital NHS Foundation Trust consists of one medium-sized district general hospital. The trust provides a full range of hospital services including an emergency department, critical care, general medicine including elderly care, general surgery, paediatrics and maternity care. In total, the trust has 517 hospital beds. In addition to providing general acute services, Milton Keynes Hospital increasingly provides more specialist services, including cancer care, cardiology and oral surgery.

We inspected Milton Keynes Hospital NHS Foundation Trust as part of our comprehensive inspection programme in October 2014. Overall, we rated this trust as "requires improvement and noted some outstanding practice and innovation. However, improvements were needed to ensure that services were safe, effective, and responsive to people's needs.

We carried out a focused, unannounced inspection to the trust on 12, 13 and 17 July 2016, to check how improvements had been made in the urgent and emergency care, medical care and end of life care core services. We also inspected the maternity and gynaecology service.

Overall, we inspected all five key questions for the urgent and emergency care and medical care core services and found that improvements had been made so that both core services were now rated as good overall.

For the maternity and gynaecology service, at the last inspection, all five key questions were rated as good. At this inspection, we rated safety and well-led as good.

We found that significant improvements had been made in the end of life care service and that the key question of safe was now rated as good.

Applying our aggregation principles to the ratings from the last inspection and this inspection, overall, the trust's ratings have significantly improved to be good overall. This was because four key questions, namely effective, caring, responsive and well-led, were rated as good, with safe being requiring improvement.

Our key findings were as follows:

- All staff were passionate about providing high quality patient care.
- Patients we spoke to described staff as caring and professional. Patients told us they were informed of their treatment and care plans.
- The emergency department was meeting the 95% four hour to discharge, or admission target, with a clear escalation processes to allow proactive plans to be put in place to assist patient flow. For July 2016, the department was performing at 96%.
- The emergency department leadership team had significantly improved the department's performance in meeting the four hour target to improve safety in seeing and assessing patients. The department leaders had implemented a range of systems and processes to drive improvements throughout the service.
- The Hospital Standardised Mortality ratio (HSMR) was significantly better the expected rate and generally outcomes for patients were positive.
- Whilst bed occupancy was very high, at 97%, above the threshold of 90%, patient flow was generally effective in the service.
- The service performed well for referral to treatment times; scoring 97% across the medical specialities.
- Improvements had been made in the completion and review of patients' 'do not attempt cardio pulmonary resuscitation" forms.
- The trust had established a maternity improvement board to review incidents and risks and to drive improvements in the service. Information was used to develop the service and continually improve.

Summary of findings

- There was a lower rate than the national average of neonatal deaths. The maternity improvement board was monitoring this to make further improvements in the service.
- The culture within the nursing and midwifery teams was caring, supportive and friendly.
- Safety concerns and risks were monitored regularly in the maternity service and plans were in place to address areas of concern. Changes in practice and training had been put in place following lessons learned from incidents.
- Staff knew how to report incidents appropriately, and incidents were investigated, shared, and lessons learned.
- Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- There were generally effective systems in place regarding the handling of medicines.
- Equipment was generally well maintained and fit for purpose.
- Staffing levels were appropriate and met patients' needs at the time of inspection.
- Patients' individual care records were written and managed in a way that kept people safe
- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Mandatory training generally met or was near to meeting trust targets.
- Appropriate systems were in place to respond to medical emergencies. Appropriate systems and pathways were in place to recognise and respond appropriately to deteriorating patients.
- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.
- Staff morale was positive and staff spoke highly of the support from their managers.
- Local ward leadership was effective and ward leaders were visible and respected.

We saw several areas of outstanding practice including:

- The medical care service had a proactive elderly care team that assessed all patients aged over 75 years old. This team planned for their discharge and made arrangements with the local authority for any ongoing care needs.
- The medical care service ran a 'dementia café' to provide emotional support to patients living with dementia and their relatives.
- Ward 2 had piloted a dedicated bereavement box that contained appropriate equipment, soft lighting, and bed furnishings to provide a 'homely' environment for those patients requiring end of life care.

However, there were also areas of poor practice where the trust needs to make improvements:

- The emergency department did not fully comply with guidance relating to both paediatric and mental health facilities. The paediatric emergency department had a door that was propped open, allowing access by all staff and patients presenting potential security risks The ED did not a have dedicated mental health assessment room that had had a robust risk assessment, allowing equipment in the room to be used as missiles. The trust took immediate actions to address this during the inspection to make these areas safe.
- Initial clinical assessments were not always carried out in a timely way in the paediatric area, and escalation for medical review and assessment was inconsistent. This was escalated to the trust who took immediate actions during the inspection to address this. This was followed up on the third day of inspection and all children had been clinically assessed within the 15-minute period. The trust also ensured this was actively monitored on an ongoing basis.
- There were inconsistent checks of resuscitation equipment throughout the department, not in line with trust policy. The trust took urgent action to address this during the inspection and to monitor this on an ongoing basis.
- Staff, patients and visitors did not observe appropriate hand washing protocols when entering/leaving the department or when moving between clinical areas. The trust took action to address this and to monitor on an ongoing basis.
- Some patients' privacy was not respected when booking in at the reception desk in the emergency department when the department was busy.

Summary of findings

- The non-invasive ventilation policy was out of date and had not been reviewed. New guidance relating to this had been released in March 2016, which meant there was a risk that staff were not following current guidelines. The service was aware that it was out of date and was planning to review this; however, there was no time scale for this.
- The medical care service did not have a specific policy for dealing with outlying patients, and therefore, there was no formal procedure to follow in these instances.
- External, regional health service planning had affected the maternity service's development plans.
- In the maternity service, some examples were shared with inspectors of poor communication, inappropriate behaviours and lack of teamwork at consultant level within the service. From discussion with senior managers, it was clear that some issues had been recognised and active steps were being taken to optimise communication and team working. Such behaviours were not observed during the inspection.
- Not all medical staff had the required level of safeguarding children's training.
- There was poor compliance with assessing the risk of venous thromboembolism (VTE) and the maternity service had actions plans to place to address this concern.

Importantly, the trust should:

- Review and monitor the access and security of both the adult and paediatric emergency departments.
- Monitor the facilities available for respecting the privacy and confidentiality of patients and relatives during the booking in process in the adult and paediatric emergency departments.
- Monitor the initial clinical assessment times within the paediatric emergency department.
- Monitor that recommended checks are carried out on all resuscitation equipment and documented the adult and paediatric emergency departments.
- Review and monitor the mental health assessment room to ensure it is fit for purpose in the adult emergency department.
- Monitor the effectiveness of staff, patient and relatives' adherence to infection control procedures within the adult and paediatric emergency departments.
- Monitor staff compliance with mandatory training requirement to meet the 90% trust target in the adult and paediatric emergency departments.
- Ensure that all resuscitation and emergency trolleys are fit for purpose and robust audits are completed.
- Ensure that agency staff have appropriate induction with evidence of completion.
- Review the isolation facilities available on Ward 17 for patients with infections.
- Review the storage of hazardous chemicals and needles to ensure that no unauthorised people could have access.
- Review the non-invasive ventilation policy, incorporating the new guidance available.
- Review the consistency of consultant cover out of hours and at weekends across the medical wards.
- Review the arrangements for timely discharge of patients from the AMU.
- Review the procedures for the management of outlying patients.
- Review the process for recording the number of bed moves for patients, including out of hours and at weekends.
- Review the specific arrangements for caring for patients with autism.
- Review the completion of assessments for venous thromboembolism (VTE) to ensure patients' safety needs are met.
- Review arrangements for monitoring the cleaning of equipment in the maternity service.
- Review the provision of pain relief provided to women in labour to ensure patients' needs are met.
- Review the arrangements for post-operative recovery to ensure mothers and babies can be cared for together, unless in emergencies.
- Monitor the safeguarding children's training provision for medical staff in the maternity service.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	We rated the emergency department (ED) as good overall. We found there to be improvements made since the last comprehensive inspection in October 2014. It was judged to require improvement for safety and good for effectiveness, caring, responsiveness and well led. We found that:-

- The department was meeting the 95% four hour to discharge, or admission target, with a clear escalation processes to allow proactive plans to be put in place to assist patient flow. For July 2016, the department was performing at 96%. The rapid assessment hub was efficient and ensured patients in majors received timely initial assessment and treatment.
- The leadership team had significantly improved the department's performance in meeting the four hour target to improve safety in seeing and assessing patients. The department leaders had implemented a range of systems and processes to drive improvements throughout the service.
- There were robust meetings for clinical improvement and governance and learning from incidents was disseminated throughout the department.
- All staff were passionate about providing high quality patient care. Patients we spoke to described staff as caring and professional. Patients told us they were informed of their treatment and care plans.
- Evidence based guidelines were used within the department and were relevant and up to date.
- The department had a clear strategy and vision to continuously improve the service. Staff morale was positive and staff spoke highly of the support from their managers.
- Nurse staffing levels met patients' needs at the time of the inspection and the department liaised with the paediatric ward to rotate the trained children nurses to work in the paediatric emergency area. Medical staffing met national recommendations and effective out of hours cover was provided.
- Staff were competent in the roles and supported via effective appraisals and supervision.
- Multidisciplinary working was in evidence in the department.

Summary of findings

- Suitable arrangements were in place to safeguarding children and adults.
- Medicines were generally managed safely.
- Appropriate systems and pathways were in place to recognise and respond appropriately to deteriorating patients. Appropriate arrangements were in place to provide safe and treatment for people with vulnerabilities.

However, we also found that:

- The department did not fully comply with guidance relating to both paediatric and mental health facilities. The PED had a door that was propped open, allowing access by all staff and patients presenting potential security risks The ED did not a have dedicated mental health assessment room that had had a robust risk assessment, allowing equipment in the room to be used as missiles. The trust took immediate actions to address this during the inspection to make these areas safe.
- Initial clinical assessments were not always carried out in a timely way in the paediatric area, and escalation for medical review and assessment was inconsistent. This was escalated to the trust who took immediate actions during the inspection to address this. This was followed up on the third day of inspection and all children had been clinically assessed within the 15-minute period. The trust also ensured this was actively monitored on an ongoing basis.
- There were inconsistent checks of resuscitation equipment throughout the department, not in line with trust policy. The trust took urgent action to address this during the inspection and to monitor this on an ongoing basis.
- Staff, patients and visitors did not observe appropriate hand washing protocols when entering/ leaving the department or when moving between clinical areas. The trust took action to address this and to monitor on an ongoing basis.
- Not all risks in the department had been recognised and assessed since the last inspection, such as ensuring patients privacy within the department; this

Summary of findings

was observed in the booking in process and doors being left open into the paediatric emergency department. The trust took immediate action to address this during the inspection.
- Some patients' privacy was not respected when booking in at the reception desk when the department was busy.

Medical care (including older people's care)

Good

Overall, we rated medical care at this hospital to be good because:

- The Hospital Standardised Mortality ratio (HSMR) was significantly better the expected rate and generally outcomes for patients were positive.
- Staff understood their responsibilities to raise concerns and report incidents and near misses and learning from incidents was used to drive improvements across the service.
- Infection prevention and control was generally robust, with staff adhering to the infection control policy.
- All equipment viewed was in service date, and had been maintained or electrically safety tested and was fit for use.
- Records were kept securely and were completed appropriately.
- Risks to patients were identified and escalated appropriately.
- Nurse staffing levels were appropriate, with staff flexed to cover vacancies.
- Patients generally had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. Risks to patients were identified and escalated appropriately.
- Staff generally had a good understanding of the Mental Capacity Act and consent to care.
- Patients received compassionate care, and patients were treated with dignity and respect. We saw that staff interactions with patients were person-centred and unhurried. Staff were focused on the needs of patients and improving services.
- Whilst bed occupancy was very high, at 97%, above the threshold of 90%, patient flow was generally effective in the service.
- The service performed well for referral to treatment times; scoring 97% across the medical specialities.

Summary of findings

- Services met patients' needs, especially those living with dementia.
- Local ward leadership was good and ward leaders were visible and respected.
- There was a positive culture across the medical wards with staff telling us they enjoyed working at the trust. Morale was high across teams.

However, we also found that:

- Across a number of wards, we found resuscitation trolleys were not checked consistently. On inspection, we found where they had been checked, equipment and some medicine inside the trolleys were found to be out of date. We raised this as a concern and the trust took immediate action to address this by reviewing all resuscitation trolleys and ensured that ward leaders were accountable for these checks.
- Induction of agency staff was not always robust as some wards did not follow the trust's policy for agency staff induction and we founds some wards were not keeping any records of these inductions.
- We found that medicines were not always stored securely or safely on wards 15 and 16.
- The non-invasive ventilation policy was out of date and had not been reviewed. New guidance relating to this had been released in March 2016, which meant there was a risk that staff were not following current guidelines. The service was aware that it was out of date and was planning to review this; however, there was no time scale for this.
- Not all patients were routinely being transferred or discharged from AMU within 72 hours of admission, though the service had reduced the number of patients with longer than planned stays from April to July 2016. The service did not have an action plan to improve their performance. We were advised that this had recently been added to the trust's transformation work streams.
- Whilst the risk register generally reflected the wards' safety and quality of care and treatment, we did find some risks were not recorded on the service's risk register.

Maternity and gynaecology

Good

On the last inspection, all five key questions were rated as good. At this inspection, we rated safety and well-led as good. We found that:

Summary of findings

- The trust had established an improvement board to review incidents and risks and to drive improvements in the service. Information was used to develop the service and continually improve. The service was focused on continuous improvement.
- There was a lower rate than the national average of neonatal deaths. The maternity improvement board was monitoring this to make further improvements in the service.
- Changes in practice and training had been put in place following lessons learned from incidents. Improvements had been made in response to serious incidents.
- There was sufficient equipment on the wards to keep women and babies safe including new areas for resuscitating babies, blood pressure monitoring devices and a centralised cardiotocography (CTG) system. Systems were in place to make sure that women were monitored and looked after closely.
- Whilst there was not always adequate space for storage of equipment not in use, the service had noted this as a risk and had raised awareness amongst staff teams to constantly assess the situation for risks to patients.
- Staff were adequately trained, encouraged, and supported to continue with their professional development. Midwifery, gynaecology nurse, and medical staffing met patients' needs at the time of inspection.
- At times of peak demand, the service escalated the overall safety status of the maternity unit as necessary. Appropriate escalation plans were in place.
- There was a clear vision for the service and staff understood the trust's values.
- Leadership was well defined and visible. Leaders had been appointed in all the maternity and gynaecology sub specialities with clear work plans and objectives.
- Midwives and gynaecology nurses' roles had been developed to support the service and provide a greater level of expertise for patients.
- Governance, risk management and quality measurement systems were in place and used to monitor and improve safety, treatment and outcomes for patients.

Summary of findings

- The culture within the nursing and midwifery teams was caring, supportive and friendly. All nursing and midwifery staff we spoke to told us that they were happy at work.

However we also found that:

- Some gaps in emergency trolley documented checks were found and the service actioned this immediately when we raised it as a concern.
- There was poor monitoring of the risk of venous thromboembolism (VTE) and the service had actions plans to place to address this concern.
- Women could be separated from their babies after a caesarean section due to limited recovery space in the operating theatres.
- There were at time gaps in the implementation and recording of information about intentional rounding carried out on labour ward. The service was monitoring the completion of these records.
- External, regional health service planning had affected the service's development plans.
- In the maternity service, some examples were shared with inspectors of poor communication, inappropriate behaviours and lack of teamwork at consultant level within the service. From discussion with senior managers, it was clear that some issues had been recognised and active steps were being taken to optimise communication and team working. Such behaviours were not observed during the inspection. The service website information was very limited.

End of life care

Good

Overall, we rated the service as good for safety. Significant improvements had been made since the October 2014 inspection. We inspected the safe key question and we found that:

- Improvements had been made in the completion and review of patients' 'do not attempt cardio pulmonary resuscitation" forms.
- Staff knew how to report incidents appropriately, and incidents were investigated, shared, and lessons learned.
- Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- There were effective systems in place regarding the handling of medicines.

Summary of findings

- Equipment was generally well maintained and fit for purpose.
- Chemicals hazardous to health were generally appropriately stored.
- Risks in the environment and in the service had been recognized and addressed.
- Staffing levels were appropriate and met patients' needs at the time of inspection.
- Patients' individual care records were written and managed in a way that kept people safe
- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Mandatory training was provided for staff and compliance was 100%.
- Records were accurate, well maintained and stored securely.
- Appropriate systems were in place to respond to medical emergencies.
- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.

Milton Keynes Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Maternity and gynaecology and End of life care.

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Milton Keynes Hospital	13
Our inspection team	13
How we carried out this inspection	13
Facts and data about Milton Keynes Hospital	14
Our ratings for this hospital	14
Findings by main service	15

Background to Milton Keynes Hospital

Milton Keynes University Hospital NHS Foundation Trust consists of one medium-sized district general hospital. Monitor (now amalgamated into NHS Improvement) authorised the trust as a foundation trust in October 2007. An NHS foundation trust is still part of the NHS, but the trust has gained a degree of independence from the Department of Health.

The trust provides a full range of hospital services including an emergency department, critical care, general medicine including elderly care, general surgery, paediatrics and maternity care. In total the trust has 517 hospital beds. In addition to providing general acute services, Milton Keynes Hospital increasingly provides more specialist services, including cancer care, cardiology and oral surgery.

The trust serves a population of 252,000 living in Milton Keynes and the surrounding areas. Milton Keynes is an urban area with a deprivation score of 192 out of 326 local authorities (with 1 being the most deprived). Life expectancy for men is worse than the England average, but for women is about the same as the England average.

- The trust employs 3,000 staff.
- The trust has beds for 400 patients.
- 84,000 people come to the emergency department every year.
- The trust treats 20,000 elective patients, 200,000 outpatients, and delivers over 4,000 babies every year.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Bernadette Hanney, Head of Hospital Inspection, Care Quality Commission.

Inspection Manager: Phil Terry

The team included a CQC inspection manager, four CQC inspectors and six special advisors, including consultants and senior nurses.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

- Is it responsive to people's needs?
- Is it well-led?

This unannounced, focused inspection took place on 12, 13 and 17 July 2016 to inspect those core services that required improvement at the October 2014 comprehensive inspection. As this was a focused inspection, we did not gather evidence across all of the five key questions in the end of life care service, focusing on safety. We also looked at the key question of safety and well-led for the maternity service.

Before visiting, we reviewed a range of information we held as well as information available regarding the emergency department's performance.

We spoke with 92 staff in the hospital, including nurses, junior doctors, consultants, senior managers and 35 patients and their relatives. We visited the adult and children's emergency department, medical care wards, maternity and gynaecology services and the end of life care service. We reviewed 78 patients' records.

We would like to thank all staff, patients, carers for sharing their balanced views and experiences of the quality of care and treatment at Milton Keynes Hospital.

Facts and data about Milton Keynes Hospital

The trust serves a population of 252,000 living in Milton Keynes and the surrounding areas. Milton Keynes is an urban area with a deprivation score of 192 out of 326 local authorities (with 1 being the most deprived). Life expectancy for men is worse than the England average, but for women is about the same as the England average.

- The trust employs 3,000 staff.
- The trust has beds for 400 patients.
- 84,000 people come to the emergency department every year.
- The trust treats 20,000 elective patients, 200,000 outpatients, and delivers over 4,000 babies every year.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	N/A	N/A	N/A	Good	Good
End of life care	Good	N/A	N/A	N/A	N/A	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Applying our aggregation principles to the ratings from the last inspection and this inspection, overall, the trust's ratings have significantly improved to be good overall. This was because four key questions, namely effective, caring, responsive and well-led, were rated as good, with safe being requiring improvement.

Urgent and emergency services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The emergency department (ED) at Milton Keynes Hospital provides a 24-hour service, seven days a week to the local population.

The department consists of a minor's area with nine trolleys, which can be used for ambulatory (walking) majors patients when needed and a separate plaster and eye examination room, 10 majors cubicles and five resuscitation bays. They have a new Rapid Assessment Hub, which has five trolleys for rapid assessment of patients who arrive by ambulance. There is a separate paediatric emergency department (PED) with its own waiting room, four cubicles and one room used as a high dependency area or treatment room. There is an observation unit within the ED, which allows up to seven patients on beds to be cared for until they are discharged or admitted. The ED has its own dedicated x-ray department, with a small waiting area.

The ED saw 139,647 patients from April 2015 to March 2016, of these patients 21,113 were aged 18 and below, this accounts for approximately 25% of attendances. The ED admission rates for 2015 to 2016 were 12.2%; this is half the England average. This was partly due to the introduction of an 'EPIC (Emergency Physician-in-Charge) clinician' who, along with the nurse-in-charge and tracker, oversees flow in the department as well assisting the middle grade and junior staff with clinical decision-making and procedures. Also a factor was that GP patient referrals were direct admissions to the surgical assessment unit or the acute medical unit. A shop-floor-based consultant carries out this EPIC function for sixteen hours per day whilst a middle grade doctor takes on the role overnight.

The ED was built in 1984 for an expected attendance of 17,000 patients per year. The trust has a business plan to integrate an urgent care centre next to the ED, which will enable the department to increase and change some of their areas to accommodate the increasing population.

Patients who attended the ED should be expected to be assessed and admitted, transferred or discharged within a four-hour period in line with the national target.

We inspected this service in October 2014 and the department was found to require improvement, specifically in the areas of safety, caring, responsive and well led. During this inspection, we focused on whether changes had been made in regards to these areas. We inspected the ED on 12, 13 and 17 July 2016.

We visited all clinical areas and the observation unit. We spoke with 30 members of staff, including, medical, nursing, reception, security and senior management staff. During the three days, we spoke with 10 patients. We observed care and treatment as well as the daily running of the department. We reviewed 35 sets of patients' records and associated records and reviewed information provided by the trust.

Urgent and emergency services

Summary of findings

We rated the emergency department (ED) as good overall. We found there to be improvements made since the last comprehensive inspection in October 2014. It was judged to require improvement for safety and good for effectiveness, caring, responsiveness and well led. We found that:-

- The department was meeting the 95% four hour to discharge, or admission target, with a clear escalation processes to allow proactive plans to be put in place to assist patient flow. For July 2016, the department was performing at 96%. The rapid assessment hub was efficient and ensured patients in majors received timely initial assessment and treatment.
- The leadership team had significantly improved the department's performance in meeting the four hour target to improve safety in seeing and assessing patients. The department leaders had implemented a range of systems and processes to drive improvements throughout the service.
- There were robust meetings for clinical improvement and governance and learning from incidents was disseminated throughout the department.
- All staff were passionate about providing high quality patient care. Patients we spoke to described staff as caring and professional. Patients told us they were informed of their treatment and care plans.
- Evidence based guidelines were used within the department and were relevant and up to date.
- The department had a clear strategy and vision to continuously improve the service. Staff morale was positive and staff spoke highly of the support from their managers.
- Nurse staffing levels met patients' needs at the time of the inspection and the department liaised with the paediatric ward to rotate the trained children nurses to work in the paediatric emergency area. Medical staffing met national recommendations and effective out of hours cover was provided.
- Staff were competent in the roles and supported via effective appraisals and supervision.
- Multidisciplinary working was evidence in the department.
- Suitable arrangements were in place to safeguarding children and adults.
- Medicines were generally managed safely.
- Appropriate systems and pathways were in place to recognise and respond appropriately to deteriorating patients. Appropriate arrangements were in place to provide safe care and treatment for people with vulnerabilities.

However, we also found that:

- The department did not fully comply with guidance relating to both paediatric and mental health facilities. The PED had a door that was propped open, allowing access by all staff and patients presenting potential security risks The ED did not a have dedicated mental health assessment room that had had a robust risk assessment, allowing equipment in the room to be used as missiles. The trust took immediate actions to address this during the inspection to make these areas safe.
- Initial clinical assessments were not always carried out in a timely way in the paediatric area, and escalation for medical review and assessment was inconsistent. This was escalated to the trust who took immediate actions during the inspection to address this. This was followed up on the third day of inspection and all children had been clinically assessed within the 15-minute period. The trust also ensured this was actively monitored on an ongoing basis.
- There were inconsistent checks of resuscitation equipment throughout the department, not in line with trust policy. The trust took urgent action to address this during the inspection and to monitor this on an ongoing basis.
- Staff, patients and visitors did not observe appropriate hand washing protocols when entering/ leaving the department or when moving between clinical areas. The trust took action to address this and to monitor on an ongoing basis.
- Not all risks in the department had been recognised and assessed since the last inspection, such as ensuring patients privacy within the department; this

Urgent and emergency services

was observed in the booking in process and doors being left open into the paediatric emergency department. The trust took immediate action to address this during the inspection.
- Some patients' privacy was not respected when booking in at the reception desk when the department was busy.

Are urgent and emergency services safe?

Requires improvement

We rated the service as requires improvement for safety because:

- The department did not comply with guidelines relating to paediatric facilities. The Royal College of Paediatrics and Child Health (2012) recommend that the paediatric area is secure and access is monitored and controlled. The doors were left open to allow ease of access to the children and parents to enter. However, this also meant that anyone had access to this department. This was escalated to the trust who took actions during and after the inspection to address this to make sure the area was secure.
- The department did not comply with guidance relating to mental health facilities. Whilst the room used to care for those presenting with mental health conditions had since had a full risk assessment, not all risks were mitigated. The trust took immediate action to address this during the inspection to make the area appropriate for use as a mental health assessment room.
- Initial clinical assessments were not always carried out in a timely way in the paediatric area, and escalation for medical review and assessment was inconsistent. This was escalated to the trust who took immediate actions during the inspection to address this. This was followed up on the third day of inspection and all children had been clinically assessed within the 15-minute period. The trust also ensured this was actively monitored on an ongoing basis.
- There were inconsistent checks of resuscitation equipment throughout the department, not in line with trust policy. The trust took urgent action to address this and to monitor this on an ongoing basis.
- Staff, patients and visitors did not observe appropriate hand washing protocols when entering/leaving the department or when moving between clinical areas. The trust took action to address this and to monitor on an ongoing basis.

However, we also found:

- Incidents were reported appropriately via an electronic system and investigated swiftly with learning points identified.

- There were clear systems in place to safeguard vulnerable adults and children.
- Controlled drugs which require special storage and security arrangements were stored following safe and good guidance procedures.
- Paediatric nurses from the children's ward were rotated into the PED; this meant there was a paediatric-trained nurse on every shift.

Incidents

- Staff understood their responsibility to raise safety concerns and report incidents and near misses. However, staff did not always report when they were short staffed or when demand had increased and they had to look after excessive amounts of patients.
- An electronic reporting system was used in the ED for reporting all untoward incidents. Medical, nursing and reception staff within the ED knew how to access and use this system.
- There had been no Never Events reported from June 2015 to May 2016 within the ED. A never event is a serious incident that is wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The ED reported 14 serious incidents for the same time period: five were relating to diagnostic incidents (none related to harm), five related to sub-optimal care of the deteriorating patient, one related to a medication incident, one related to an accident for example a slip, trip or fall, one was pending review and the last was awaiting categorisation.
- After investigating and learning from the five sub-optimal care of the deteriorating patient incidents, the department introduced a new RAG (red, amber and green) rating system. The investigation of these incidents was carried out in an appropriate period.
- There were no hospital acquired pressure ulcers or catheter urinary tract infections reported to the service's safety and quality dashboard. Four falls were reported over the same time period. The ED used an electronic patient safety and quality dashboard, to display this data. All staff reported patients who came into the ED with a community acquired pressure ulcer.
- Feedback from incidents was varied; staff told us that if there was a theme then feedback would be given to all staff at handovers. The department produced a newsletter which gave feedback on issues raised in the department, however, no individual feedback was given and not all staff said they read the newsletter. Leaders in the department were trying new noticeboards in the staff areas to display information relating to incidents.
- The ED had a risk lead and they meet with the lead consultant every one to two months to discuss new and ongoing incidents. There was also a clinical improvement group (CIG) in ED that met every month and all staff were invited to attend, however staff told us they did not always have the time. Attendance at these meetings had improved over the past year to 20 to 30 staff.
- We saw evidence of mortality and morbidity being discussed in the CIG meeting and a senior nurse told us that any lessons learned were shared with the rest of the team. This was done by email and internal newsletter.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The head of nursing for the ED was responsible for ensuring staff were aware of the duty of candour, and she led on investigating and managing complaints and incidents, with the help from the assistant operational manager. The head of nursing was able to give us examples of when they had applied duty of candour and how they communicated with patient and their relatives. This met with requirements and was deemed an appropriate action.
- All staff we spoke with had an understanding of duty of candour. They told us they knew the importance of being open and honest with patients if something went wrong.

Cleanliness, infection control and hygiene

- The department was visibly clean at all times during this inspection and we often saw clinical ED staff working effectively with domestic staff to complete cleaning tasks.
- The department had dedicated housekeepers who maintained cleanliness and hygiene. They had their own

cleaning schedules for the ED; however, there were no overall cleaning schedules for the nursing staff, to assure us that trolleys and equipment, including dressing trolleys had been cleaned daily. However, from the last inspection, the department should have ensured that there were cleaning schedules that included equipment such as shower chairs and stools and this had been actioned.

- We observed six sharps containers without temporary closures and needles visible. One of these was in the paediatric department. The trust's disposal of sharps policy states that all sharps bins should have temporary closing lids. These posed a potential risk to children trying to put their hand inside.
- The paediatric waiting room had toys available; however when we asked staff they were not clear whose responsibility it was to clean these. We found out that the housekeeping staff cleaned them, but it was not on their schedule or recorded.
- During the inspection, we observed one out of two arterial blood gas machines (a machine to measure the acidity and oxygen levels in an arterial blood sample) to have large splashes of blood on the surrounding wall. We informed a member of staff about this, who took action to clean the area.
- Hand washing facilities were available in each major's cubicle and we observed staff compliant with the hand washing technique and using the hand gel whilst attending to patients in the cubicles in ED. However, when staff moved from each clinical area to the next area in the ED, we did not observe the hand gel dispensers being used, particularly entering and leaving the ED from the reception area.
- On the third day of the inspection, we did not see any staff member use the hand gel dispensers when entering and leaving the ED from the reception area. In addition, no patients or relatives were reminded to use the hand gels provided. We escalated this to senior managers who took immediate action to address this. The trust sent an email to all staff explaining that they should all be using hand gel when entering and leaving the premises as well as encouraging visitors to do the same thing. Since the inspection, they have put posters in reception and the department to remind patient and visitors to use the hand washing facilities and hand gels. There is now a point on entering the department to tell staff, patients and visitors to stop and use the hand sanitiser. An audit carried out since these procedures were put into place showed robust compliance by all staff, except one, who was immediately stopped and told of the trust procedures.
- Nursing and medical staff were not always compliant with the trust's bare below the elbow policy we observed. All staff said they felt confident to challenge visiting clinicians coming into their department. However, we did not observe this happening in practice during all days of the inspection. Since the inspection, the department carried out an audit checking compliance with the bare below the elbow policy and all staff were compliant. The service would be monitoring this on an ongoing basis.
- Personal protective equipment was available throughout the department and was utilised in accordance to the trust's infection control policy.
- Disposable curtains were around all cubicles. They were supposed to be changed every six months according to trust policy, unless visibly soiled; however, the dates when they were changed was not visible on 10 out of 27 we looked at. Staff said they had been changed within the correct timescales, but this had not been recorded.
- The department had three side rooms available for patients requiring isolation. Signs were used to alert staff and visitors on the doors. Nursing and medical staff could explain how isolation procedures were followed within the department and which patients would require isolated care. The department also had a specific isolation room which would be used for patients presenting with Ebola.
- The sluice area on the last inspection was found to be untidy and the floor dirty; however during this inspection it was tidy and clean, with green 'I am clean' stickers on the commodes to say that they had been cleaned.
- The waiting room chairs were old and many of them ripped, so padding was exposed. This was seen to be an infection control risk; new chairs had arrived that were waiting to be installed.
- Infection control was part of the trust's mandatory training and had been attended by 86% of staff, which was slightly below the trust target of 90%.

Environment and equipment

- The design, maintenance and the use of facilities was not always appropriate to keep people safe. There were

concerns in both the main ED and the separate paediatric emergency department (PED). Similar concerns were observed during the last inspection in October 2014.

- The overall security of the main door to the ED from the reception area was not secure, as staff did not always follow trust policy by keeping the door locked shut. Frequently, we observed that this door was left open and that patients and visitors were able to walk in and out of the ED from the reception area without staff present. We also saw some visitors walking about the ED without staff challenge over a 20-minute period. This presented risks that unauthorised people could access the ED and also that patients could leave the ED without staff knowledge.
- We raised this as a concern with the trust, who took immediate action to address this by reminding staff to keep door shut at all times and challenge staff and relatives who are entering. This was done by a letter to all staff in the ED. They had commenced a new audit for security staff to check these doors each day to ensure they are closed.
- We observed during our inspection that the double doors into the PED were both left open, which led into the adult area of the ED. We observed two members of the public walking in from the main ED trying to find their way to the exit. The PED was visible from the main hospital corridor when the doors were open. We asked staff if they were always open, and they explained yes they were, due to ease of access when children were directed through from the reception.
- This issue was escalated immediately to the trust and when we returned later that day, the doors were both shut, but still unlocked. The doors had a keypad on to enable them to be locked; however this was not used. We saw during our third day of inspection that there was a notice on the door to please keep doors closed but they were still unlocked. Following our inspection, the trust carried out a risk assessment on the PED and the doors were now consistently closed with a poster on explaining this was a restricted area and not to enter. Further assurances from the trust had shown the instalment of a 'buzzer' entry system, with locked doors. This meant that the PED was now secure in line with guidance.
- The paediatric waiting area in the PED had a large window across into the main ED, which made it visible to the adult patients and relatives. Health Building Note 15-012013 (this is a Department of Health document giving planning and design guidance for emergency department) states that areas where children wait should allow observation by staff but not allow patients or visitors within the adult area to view the children waiting. Senior leaders in ED explained that this issue would be addressed with the refurbishment plans for both the adult ED and PED.
- The trust told us that the service will be changing the layout and entrance into the PED with the development of an urgent care centre. They will have a separate entrance with doors limiting access from the main ED, with an entry system to control access to all areas of the department. The timescales for the commencement of the refurbishment work had not yet been agreed but the trust's executive team and the local clinical commissioning group were discussing the plans.
- Records of checks of the resuscitation trolleys were not completed in line with trust policy in the adult ED. We observed omissions in the daily and weekly check, in one trolley out of two that we checked. The nurse in charge was made aware and on our unannounced visit, the checks had been completed in accordance to trust policy. The resuscitation trolley in the PED was checked daily in accordance with trust policy.
- We checked the 'grab' bag in the main adult resuscitation area: these are small bags with resuscitation equipment that could be used in areas too small for a trolley or on transfers to other areas of the hospital. We found out of date adrenaline and defibrillation pads in this grab bag. These were discarded and changed after we notified the staff. There were no records of these being checked.
- The paediatric transfer bag, which has resuscitation equipment in for transferring an unwell child to other areas of the hospital, had a bag valve mask (BVM, used to assist a child in respiratory distress) which expired in May 2015, and the bag was overstocked, which would make finding equipment in a timely manner difficult. On checking the neonatal 'grab' box, dressings and a urinary catheter were found to be out of date.
- In the treatment/high dependency room the bag valve mask mouthpieces were stored on a dusty shelf not in their sterile packaging.
- Staff were immediately alerted to these concerns and took immediate action to address this during the day of the inspection.

- We raised also this an a concern with the trust, who took actions to ensure all resuscitation equipment in both the adult ED and PED would be checked daily to ensure it was safe for use and that audits would be carried out with immediate effect. All staff were reminded of the importance of checking all resuscitation equipment.
- Patients told us that they found the layout of the ED confusing, as there were no clear signs for the minor's area or the exit and patients were seen to be wandering looking for the way out.
- The ambulance entrance to the ED was secure and only accessible with a card swipe access by staff.
- In the reception area, there was a dedicated triage room. This room was isolated from the rest of the department but had an alarm system. We observed during our inspection that the door was left open when they were assessing patients. We spoke with staff who explained they left it open due to not feeling safe with the door shut. This room was not directly visible to the staff who worked on the reception desk.
- There had been a previous incident where a staff member had been physically assaulted by a patient in the triage room when the door was closed and had to shout for help, due to no alarm system being in the triage room. Also, the blood taking trolley and dressing trolley in the triage room was visible to all the waiting room, which posed a potential risk of needles and equipment being stolen when the room was not staffed, and patients' privacy was compromised when being assessed in this room. We found that a formal risk assessment had not been completed to assess this risk. We raised this as a concern with the trust, who took action to address this risks assessing and by changing the layout of the triage room
- There was no dedicated mental health assessment room within the department: this was observed during the last inspection and had not changed. However, a room which was situated off the main waiting area, which had had a ligature assessment, but not a full environmental risk assessment, was used to care for patients presenting with mental health conditions. The Royal College of Emergency Medicine 2013 (RCEM) guidance requires assessment rooms to have an alarm system, two doors, and no objects that could be used as missiles and no ligature points. However, this room had no alarm system, only one door and equipment and furniture was not secure. This could result in potential harm to both patient and staff. This was on the ED risk register, but had not been reviewed since April 2016. This was escalated as a concern during the inspection and the trust carried out a full risk assessment of the designated room and put actions in place to mitigate risks to patients and staff.
- The waiting room floor had two obvious tears in the flooring posing a potential trip hazard. A patient raised their concern regarding these matters to us during the inspection. We alerted this to the head of nursing for ED at the time of inspection, who assured us that the plans were in place for new flooring in the whole department.
- The reception staff told us they felt safe, as they had a door behind them they could use to get help and a panic button; however, they explained to us that having no screen between them and the patients did leave them feeling vulnerable at times, especially during the night.
- The ED obtained its equipment from a main hospital store and staff reported no delays in obtaining necessary equipment.
- We looked at equipment that was currently being used within the department and all equipment we checked had received appropriate portable appliance testing in accordance to the trust policy.
- Staff informed us that bariatric equipment was available when required, including a bed and wheelchair.
- The major's layout had changed in the last 12 months; a large centre desk was removed, as patients and relatives could hear private discussions and telephone calls among the staff. This had improved the patient and relatives experience since the last inspection.

Medicines

- Arrangements for managing medicines, and medical gases were in place to keep people safe, however there were some concerns in relation to the storage of medicines.
- Medicines in the ED were found to be stored in an untidy manner in the main medicines cupboard and in the resuscitation area. We found oral medicine stored on the same shelves as intravenous (IV) medicine, and in no systematic order. This meant there was a risk of picking up the wrong medication for a patient.
- During the inspection, we found oral medicine not stored correctly in their relevant boxes, this meant

tablets in their blister packs were placed haphazardly on the shelves. Oral medication should be kept in their appropriate box to enable careful checking of the type of drug and the expiry date.

- Medicine refrigerator temperatures were not always recorded daily to ensure medicines were stored within the safe temperature range. The fridge in the resuscitation room was unlocked during our inspection
- These concerns were raised to the senior nursing team at the time of inspection. We checked both drug cupboards during the third day of the inspection and both cupboards were organised and tidy, and fridge temperatures had been checked each day and were both locked.
- The main drug cupboard was kept secure at all times with a swipe access, only staff could use. The medications cupboard in resuscitation was accessible only with two keys and was secured to the wall.
- We saw that controlled drugs were stored securely. Controlled drugs are medicines that have a legal requirement to be stored in a secure way and their use recorded in a register.
- Intravenous fluids were kept in a locked cupboard accessible by a coded keypad.
- Room temperatures were regularly checked and temperatures recorded which meant medicines were stored at the correct temperatures
- We observed staff preparing and administrating IV medicine in accordance with national guidance.
- Out of five drug records we reviewed, all contained patients' allergy status and patients wearing the correct allergy wristband corroborated this. Checks to ensure that any known allergies or sensitivities to medicines were recorded accurately on patients' prescription charts within 24 hours of admission. This information is important to prevent the potential of a medicine being given in error and causing harm to a patient.
- We saw that drug errors such as missed doses or incorrect doses were recorded as incidents and discussed in the department's monthly meetings. We saw no omissions or errors when looking at patient drug records.

Records

- Records were generally written and managed in a way that kept people safe, and respected patient's confidentiality; however, we observed patient hospital stickers; these contained patients' names, addresses and hospital numbers, stuck on desks and around a computer base located in majors. This was brought to staffs' attention on the third day of inspection and rectified.
- During our inspection, records were stored appropriately in a drawer system in majors with the numbers of the cubicles written on each drawer.
- Patient records in the observation unit were locked in a designated notes trolley.
- We reviewed 30 sets of patient notes, and five sets of paediatric notes, almost all of which had been completed in accordance with trust policy. The time to assessment was written on notes and recorded electronically. All contained evidence of a senior review, all had allergy status clearly documented, all had a National Early Warning Score (NEWS, a simple system of scoring clinical observations to provide a single number that indicates the patients clinical state) documented.
- One record did not document a triage time. One set did not have signatures, dates or times documented after each interaction with the member of staff. Patient's pressure areas management needs were documented when necessary.
- The department had a separate nursing assessment booklet, which was only started when the patient had been in the department over six hours. This included risk assessments for falls, pressure ulcers and nutrition and hydration needs. Nursing staff told us that if a patient was presenting as a high risk in any of these areas they would start the booklet on arrival. During the inspection, we saw evidence of this assessment booklet used in patient's records who had been in the department for more than six hours.
- The patients four hour breach time was documented clearly on their ED computer system and on the front of the notes manually written in red by the reception staff. The four-hour target in emergency departments was introduced by the Department of Health for NHS acute hospitals in England. Since June 2010, this target has been 95%.
- The original paper records did not leave the ED. Processes were in place for photocopying the records when patients were allocated a bed on the ward, and they were scanned into the ED system for future reference.

Safeguarding

- The service had systems that were in place to ensure vulnerable adults and children were kept safe. However, whilst staff said they were aware of their responsibilities in relation to safeguarding, we did not always see this being carried out in practice during the inspection.
- We observed young children walking unaccompanied from the PED, through adult ED into the reception area and back again on three occasions. We escalated this immediately as a concern to the trust, who took immediate actions to address this. All ED staff were reminded of their responsibilities to remind all relatives that all children must not be left unaccompanied to ensure they were kept safe in the right department. Also, since the new instalment of the secure entry system into the PED this risk was mitigated.
- All clinical staff were required to attend level three training in children's safeguarding. This was in line with national intercollegiate guidance 'Safeguarding Children and Young People: roles and competences for health care staff' dated March 2014.
- Staff completed safeguarding training at induction and level one was included in the mandatory training for both adults and children. 85% of nursing staff had completed safeguarding children level three and 90% of medical staff had completed safeguarding children level three training. The trust policy was for 90% of registered nurses and clinicians to be trained to level three in safeguarding children. The head of nursing showed us the nursing staff who were due to go on the training and that appropriate training sessions had been arranged.
- 85% of nurses had completed safeguarding adult training and 81% of medical staff had completed safeguarding adult training. This was below the trust target of 90%. 100% of reception, support staff and the ED management were up to date in both.
- The ED could refer children of concern to an outside agency called MASH (Multi-Agency Safeguarding Hub) when required and staff said this referral system worked in practice.
- In the PED, there was a safeguarding folder, which included the trust's safeguarding team contact details, the processes to make referrals, MASH contacts, and the trust's safeguarding policy. It also contained recent documentation relating to female genital mutilation (FGM) and child exploitation with learning documents included.
- If staff were concerned regarding a child being subject to physical abuse they would use there safeguarding folder for the right pathway to follow, discuss with the lead consultant and document in the patients record.
- During our inspection, the safeguarding lead nurse was in the department reviewing patient's notes as per their policy. All staff we asked knew the names of the safeguarding team and how to contact them.
- There was a designated area on children's records to record safeguarding information. Staff had access to the electronic child protection register; however, this was not used to routinely check all children in the ED. When we asked staff why, they told us the system was not easily accessible and sometimes doesn't work. When this happened, the staff mitigated this risk by informing the safeguarding team who would check the relevant documents. It is best practice to check all children against the child protection register, but it is not mandatory.

Mandatory training

- All staff were required to attend mandatory training. This covered a variety of safety systems, processes and practices including infection prevention, fire safety, information governance, manual handling, sepsis and basic life support.
- The staff in the ED; however, required further specific training in immediate and advanced life support for children and adults. All band 5 nurses had completed immediate life support for adults and children. All doctors and the senior nursing team had completed advance life support, and 14 members of both medical and nursing had completed the European paediatric advanced life support course.
- The nursing staff were split into teams, with a band 7 (senior sister) as team leader for each group. It was their responsibility to make sure that their team have been booked on and received their mandatory training.
- All nursing staff we spoke to had received mandatory training within the last 12 months, but the department's recent figures were 86% slightly below the trust's target of 90% of staff to have received training. The band 7 team had booked the members of their team onto training who were out of date. However, this was an improvement in staff compliance compared to the last inspection, where staff compliance was 76%.

Assessing and responding to patient risk

- Walk-in patients booked in at the reception desk and dependant on age were either directed into the PED or told to take a seat in the waiting room. The reception staff could visually see the whole waiting area.
- Where reception staff had particular concerns about a patient's condition, they could alert the triage nurse or the nurse in charge for immediate assessment. This was done by going through into the main department or using a 'walkie-talkie' that both the reception and the nurse in charge carried. This was helpful, especially during the night, and if a patient deteriorated whilst sat in the waiting room. Reception staff confirmed patients' demographic details and forwarded the patient's presenting concern to the triage clinician for assessment and management.
- The reception staff were trained to alert nursing staff straight away when a patient booked in with chest pain, they would then be taken into the main department to receive an electrocardiogram (ECG) to rule out a medical emergency such as a heart attack. The senior nursing team trained them; they had to alert the nurse in charge or the triage nurse if anyone mentions chest pain when booking in. However, the reception staff had no other formal training to recognise an unwell patient, and we were told of no plans to commence this.
- Patients arriving by ambulance were taken into the major's area, where they were assessed in the rapid assessment hub then streamed into the major's area or to x-ray.
- The ambulance turnaround time, which is the time between arrival of the ambulance to handover to the receiving nurse or doctor, was recorded electronically on the ambulance service's computer aided dispatch system. During our inspection, we observed all patients receiving a timely handover within the national target deadline of 30 minutes.
- All patients booked into the ED received a full, appropriate triage by a senior nurse, based upon their presentation. The triage system used within the ED was based on the Manchester Triage System. The triage system was in line with all Royal College of Emergency Medicine (RCEM) 2013 guidance.
- In the morning of the first day of the inspection, we found that out of 15 patients waiting in minors, five were not triaged within the 15-minute time to initial assessment target in adult minors, four of these were children presenting with minor injuries and one adult.
- In the afternoon of the same day, in the PED, we found nine children waiting to have their first initial clinical assessment completed. The longest wait being one hour and 30 minutes. This meant that these children had not been initially clinically assessed by any clinical practitioner during this time, with the risk of delays to clinical assessment and the provision of effective care and treatment. This was escalated to the consultant in charge and the head of nursing immediately. A second triage nurse was sent immediately into the paediatric area to help assess the waiting children.
- We asked why this increased waiting time for initial clinical assessment wasn't escalated earlier, and staff informed us that the second nurse in the PED had gone on their break. Whilst the other nurse was in a room with a patient, the queue had built up without the nurse being aware. We raised this as a concern to the trust, who took immediate actions, which included bringing in a nurse form the main ED to continue triaging children until the wait was brought back into line with the 15-minute guidance. This was an experienced ED nurse with experience of triaging children.
- During the third day of our inspection, all children were assessed within the 15-minute national target for initial clinical assessment, with two senior doctors present seeing patients.
- To measure acuity within the department, the national early warning score (NEWS), and the paediatric early warning score (PEWS) were used in the ED. Staff completing these charts in accordance with trust policy, and a pain score was included. Staff had a clear process of when to escalate to the doctors. Nurses escalated any patients who scored a seven or greater to the consultant for urgent medical review.
- The department would always aim to keep a bay free in the resuscitation area, ready for a deteriorating patient. The department had access to the trust's deteriorating patient and escalation process pathway if needed. The ED's professional development nurse had adapted this to a specific ED pathway, which staff understood.
- All patients that needed to be admitted onto the department's observation unit, for further tests or awaiting results before discharge, would be reviewed and discussed with the lead consultant, who would make the clinical decision that this was appropriate for each patient.

- For adult medical emergencies within the department, the rapid response team (cardiac arrest team) were fast bleeped to the department, for their support. With paediatric emergencies, the PED would get support from the paediatricians.
- The department has a major traumatic bleed policy and they had access to imaging department when needed in an emergency.
- The staff felt supported in the event of a sudden infant or child death. They had a policy for managing these events in line with the sudden unexpected death in infants and children procedures.
- The senior management team in the ED were in the process of updating a safety matrix tool for the ED. This is a tool to quickly assess the acuity and demand on the department at different times over a 24-hour period. It documents how many patients are in the department at one time, how many are waiting for beds, how many are on way via ambulance, and how many resuscitation trolleys are free. This enables the department and the site managers to make plans to ensure the safety of people in the ED and those who were due to arrive. There was not a planned date to start using this. During the inspection, they used a department specific escalation policy, which had roles for the lead clinician, nurse in charge and a tracker too, (for when a patient's length of stay was increasing) but nothing was formally documented at the time of the inspection.
- The trust did not perform well in repeating children's vital signs on the 2015/16 RCEM clinical audit. Not all children received a full set of vital signs, including, temperature, respiratory rate, heart rate, and oxygen saturation and the child's conscious level score within 15 minutes of arrival. They did not always use the RCEM recommended PEWS (paediatric early warning score) recording system, and if the vital signs were recorded as abnormal not all cases were acted on, and not all children that were discharged were reviewed by a senior doctor. The service had plans in place to address this. During the inspection, we saw in nine out of 10 records that a senior doctor had reviewed the junior doctor's initial assessment.
- The department had a sepsis CQUIN, (one of the Commissioning for Quality and Innovation payment frameworks) which was designed to encourage care providers to share and continually improve how care is delivered. The department's sepsis screening tool was based on the nationally recognised Sepsis Six pathway.
- We checked three patients' records for patients presenting with suspected sepsis, and they all had received timely and appropriate assessments and treatment in accordance with the trust's sepsis care pathway.

Nursing staffing

- Planned and actual staffing levels were displayed prominently within the department. The department used an electronic rostering system that identified shortfalls in staffing. They had an escalation policy for the nurse in charge to follow if there were any unexpected or short-term sickness. It would be escalated to the site manager and discussed at the morning and evening bed meetings to devise a plan. The nursing staff rotated between day shifts and night shifts, and these were both 12-hour shifts. A band 7 senior sister was in charge for each shift over the whole department including the PED.
- The planned staffing levels should have been 12 registered nurses (RNs) and four health care assistants (HCA) during the day shift, and 11 RNs and three HCAs during the night shift. During our inspection, these were the actual staffing levels observed and patients' needs were being met at the time of the inspection.
- Nursing staff told us that since the department had employed newly qualified nurses, the skill mix was inexperienced. The majority of band 5 staff nurses were newly qualified. The head of nursing for the ED had completed a business case to increase their establishment of band 6 junior sisters, from six to 21. This would ensure more band 6 experienced ED nurses working within the team and supporting the junior band 5 staff nurses, so patient care would not be compromised. The department planned to have this increase achieved within the next six months.
- The ED senior nursing team told us that they would be carrying out a business plan to increase their HCA establishment, so they could allocate five for the day shift and four during the night shift; an increase of one HCA per shift.
- The ED agency usage had significantly reduced since March 2016; however, had increased slightly again in May 2016. The ED would try to use the hospital bank (nurses who are employed by the trust, but work in a different area) for nurses to cover sickness as this was more economically sound. The electronic rostering

system showed the department had used 120 bank and agency nurses during July 2016 and 19 bank and agency health care assistants across the same month. This worked out to be two agency or bank nurse per shift.

- The trust had a policy in place for the use and induction of temporary staff, but the ED did not use this. We found that there was no record of the agency nurses' competency, qualification or formal induction to the department. This was discussed with the departments head nurse, who assured us that the agencies check all nurses' qualifications and competencies for them. However, the head nurse and the operational assistant would start to plan their own department specific agency induction for nurses, and will use the generic trust policy for agency and bank nurses until it was in place.
- During the inspection, we spoke with three bank nurses who told us they had not had a formal induction to the department; however, they were staff in other areas of the hospital and had worked regularly in the ED therefore were familiar with the layout and practices.
- The Royal College of Nursing (RCN) 2013 guidance recommends that if an emergency department has over 10,000 paediatric attendances per year, then 24 hour paediatric nursing cover should be provided. In the period April 2015 to March 2016, the ED saw 21,113 patients aged 18 and below. The department had six trained paediatric nurses, but two of these were dual trained and were often allocated to the adult ED. Where there were nurse staff shortfalls, staff from the hospital's children's ward were rotated into the ED. During our inspection, there was always a paediatric-trained nurse working in the area. This was in line with the planned number of paediatric-trained nurses to be on duty per shift, and this requirement was fulfilled for the previous three months.
- The department had five whole time vacancies for band 5 staff nurses. This represented 5% of the establishment. The department had arrangements in place for these shift to be covered, approximately 10 shifts per week. They would use the hospital bank nurses, and outside agencies if they were unfilled. Also, the head of nursing allowed staff to 'swap' shifts with colleagues of an equivalent level within the department first to try and reduce the bank and agency usage.
- Staff were allocated roles each day by the nurse in charge. These roles reflected the skills and training of the individual staff members, for example, using more experienced nurses for assessment roles in triage, resuscitation area and the rapid assessment hub.
- The department had emergency nurse practitioners (ENPs) who provided cover for the minor's department until midnight. One or two ENPs covered each shift. This was in the department's five-year plan, and to also recruit advanced nurse practitioners, who will be able to see and treat patients with minor illnesses.
- During their previous inspection in October 2014, the nursing handover took place in a room that was in constant use by doctors and ambulance personnel. This led to a disruptive process where important information could be missed, and the service was requested to review the process. This had been addressed, and the nurses now had a one-to-one handover with the outgoing nurse in the area they were allocated to. The handover notes were seen during inspection and they showed a robust system, with relevant patient information to ensure a safe handover of all treatment, care and the patient's plan.

Medical staffing

- The ED has seven permanent consultants, with three vacancies. Some of the permanent consultants chose to work extra hours. Three long-term agency consultants worked the late evening shifts and weekends. This provided the department with 16 hours of consultancy cover, seven days a week. This met the Royal College of Emergency Medicine 2010 recommendations.
- Two consultants worked from 8am to 4pm. At 4pm there was consultant cover until midnight. Then the senior cover was provided by a specialist registrar with the consultant available on call. This was provided seven days a week.
- The department had 16 middle grades (experienced doctors who have not taken their consultancy exams). This made them higher than the England average for the numbers of specialist registrars and middle grades. The England average was 52% and the department were 62%. This meant that there was always senior medical cover 24 hours a day.
- The Royal College of Emergency Medicine recommends EDs to have a consultant with sub-specialist training in paediatrics for departments seeing over 16,000 paediatric patients per year. The department did not

provide this, despite seeing 21,113 children from April 2015 to March 2016. However, they had a consultant with an interest in paediatric emergency medicine, and all consultants were required to have specific competencies and training in children's emergency care. Paediatric doctors were available on the children's ward when required.

- Locum staff were long-term agency staff who had worked in the department previously, or were experienced ED doctors from other hospitals. The lead consultant for ED reviewed their qualifications, competency and professional registration status prior to starting work in the ED. We spoke with two locum doctors during our visit. They both received a locum handbook, which included the trust policies and procedures, and an induction before the start of the shift.
- Handovers occurred throughout the shift as staff came on duty. They were structured and concise. They discussed the acuity levels of patients to prioritise care and treatment. The lead consultant was also seen to have regular discussions with the nurse in charge, to keep updated with the flow of patients through the department.

Major incident awareness and training

- A major incident policy was in place, which included procedures for internal fires, hazardous substance incidents, and patients presenting with Ebola or flu. We observed no visible signage displaying major incident information. However, this was available on the trust intranet. Which also included all plans for business continuity plans and electrical failures; these had all been discussed with their local clinical commissioning group.
- All staff had fire safety training as part of their mandatory training, and we saw evidence of staff registered on this module on the nursing rota.
- We reviewed the major incident equipment stored within the ED. It was secure and well organised, set out allowing staff easy access to everything they required. This had improved since the last inspection in October 2014.
- Staff we spoke with were aware of the major incident plan; however junior members of the team had received no training. This has been recognised by the department's senior managers who told us they would be implementing a training day within the next six months. This would include scenario practice exercises and role specific training using action cards.
- A tent was available for use outside the department, so that any patients contaminated by chemical, nuclear or biological agents could be treated appropriately. It was the responsibility of the portering team to obtain and erect the tent.
- Security personnel were not based within the department. Staff used a 'bleep' system to contact security when required. This was observed during our visit and they responded within two minutes. During our unannounced visit during the evening, security presence was witnessed. However, security staff told us they had to provide cover for the whole hospital site, which potentially meant delays in responding to the urgent 'bleep' calls. The majority of the department's incidents in the previous three months, as reported by staff, were due to violence and aggression of patients and relatives, but no harm had come to staff due to a delay in security response times.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Overall, we rated the service good in effectiveness because:

- Up to date and relevant evidence-based guidance and best practice was used within the emergency department (ED) to develop services and improve care and treatment.
- The department had a clear sepsis pathway that was used in all patients' initial assessment.
- Staff demonstrated a good knowledge of the key elements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards and understood how it related to patient care.
- The department had appointed a paediatric trained band 7 senior sister to take the nurse lead on training, and developing pathways specific for their paediatric emergency area.

However, we found that:

- Pain scores were not always re-evaluated after patients received pain relief.
- Audits showed mixed outcomes for patients in some cases.
- The department's unplanned re-attendance rate within seven days was not meeting the national standard of 5% but was generally better than the England average.

Evidence-based care and treatment

- Up to date and relevant evidence based guidance and best practice was used within the ED to develop services and improve care and treatment.
- The department used a number of evidence-based protocols. They followed National Institute for Health and Care Excellence (NICE) guidelines, and the Royal College of Emergency Medicine's 2013 (RCEM) clinical standards for emergency departments for the management of conditions such as a fractured neck of femur and the management of prophylactic venous thromboembolism (VTE) treatment in their patients requiring a lower limb plaster cast.
- The department used a number of nationally recognised pathways known as Clinical Standards for Emergency Departments' guidelines. These included the management of strokes, sepsis, major blood loss and fractured neck of femurs (broken hip). These pathways are developed by RCEM. The sepsis pathway was included in all patients' records.
- Medical and nursing staff told us they had no problem accessing cardiology guidance within the trust. The trust's cardiologist gave ED staff teaching to ensure all staff were aware of current best practice.
- Up to date clinical guidance was displayed in the resuscitation area. This meant that staff could visually see the necessary processes and treatments. The lead consultant for audits along with the head of nursing was responsible for updating these guidelines.
- All patients within the department were assessed for venous thromboembolism (VTE). The department had their own pathway for patients meriting VTE prophylaxis treatment, in particular for patients requiring a lower limb plaster cast. The pathway pack was kept in the minor's area. The trust's VTE nurse then collected the patient's details from the pack to follow up these patients at home.
- One of the ED consultants was the clinical audit lead. We received data from the trust which showed the current status of each clinical audit and the clinical lead responsible.

Pain relief

- All patients we spoke to had been asked about their level of pain and appropriate pain relief was given if required.
- The ED had a scoring tool to record patient's pain levels. Pain was scored from zero to 10, zero being no pain, and 10 being the worst possible pain. Adult pain scores were not audited within the department.
- Paediatric patients were asked to score their pain on a similar numbered system, but with the addition of pictures to aid decision making. Children's pain scores were on the departments audit plan.
- Out of the 30 patient records we reviewed, we saw that one patient did not receive appropriate pain relief. We observed minimal re-evaluation of pain once patients had been administered relief.
- Patient group directives (PGDs) were not used within the department for administering pain relief. PGDs are documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions. However, during our inspection, we spoke with the band 7 team (senior sisters), who were receiving their PGD training.
- If patients were in the department longer than six hours, the adult admission booklet was started. This had a separate section on pain assessment. Including a section which asked the patient the history and location of the pain. This was the trust's pain standard and they used scoring of one to ten, with the visual aid which was helpful for patients with dementia or learning disabilities.

Nutrition and hydration

- Patients nutritional and hydration needs were met within the department.
- Patients who were in the department over six hours had a nutritional screening tool implemented. The Malnutrition Universal Screening Tool (MUST) was used. For patients in the department less than six hours, food and fluid intake was documented in the ED nursing notes.

- In the observation unit we observed water jugs for patients, these were place within reach on their individual patient tables.
- We saw one patient who was required to be nil by mouth, and they had an appropriate prescription for intravenous fluids, and these were given in accordance to the prescription. This patient had a fluid balance chart to closely monitor their fluid input and output.

Patient outcomes

- The department had a consultant lead in audits. They carried out the plans for all audits to be undertaken and by whom. These were discussed in regular clinical improvement meetings.
- The Royal College of Emergency Medicine 2013 (RCEM) invites emergency departments to take part in national clinical audits annually which evaluate care based agreed standards. The department took part in two audits for the current year. The VTE (venous thromboembolism) risk in lower limb immobilisation in a plaster cast and the vital signs in children clinical audits.
- The trust had a good performance in the 2015/16 audit on VTE risk in patients with a plaster cast, with three out of the six measures in the upper quartile compared to other trust's, two measures were in the lower quartile relating to patient information and treatment. Plans were in place to improve these areas.
- In the 2015/16 RCEM clinical audit for vital signs in children, the trust was in the lower quartile for five out of the ten standards and two in the middle 50% of all trusts.
- In the 2013/14 audit of Severe Sepsis and Septic Shock, they met six out of the 12 RCEM standards and were in the lower quartile for three of the measures. Since this audit, the department had introduced a new screening tool for sepsis and is part of the Commissioning and Quality Innovation (CQUIN) framework. In order to achieve CQUINs, the service provider must submit evidence that they are meeting the requirements on a quarterly basis. The ED had not met all the targets for 2015/16, and the trust told us that this was because they need to change the sampling process and plans were in place to address this. The audit was a random audit and did not capture all patients presenting with sepsis. During our inspection patients, presenting with sepsis had received all assessment and treatment in line with the national targets.
- The ED was starting new audits in August 2016 for Asthma Care in adults and children in the emergency department and a new Severe Sepsis and Shock audit for the RCEM. All other audits were on a forward plan currently being completed.
- From December 2015 to February 2016, the unplanned re-attendance rate was between 6.8% and 7%; this was higher than the standard of 5% but below the England average of 7.6%.
- The department had analysed this data, looking at the frequent attenders and had two plans in development. The first is the frequent attenders and vulnerable adults risk management approach. They meet with the mental health liaison group to review interactions between local authorities in relation to episodes of care delivered to mental health patients in Milton Keynes. The second work stream was through direct engagement with the CCG, to identify high attendance patients. They identify their needs and involve the correct organisations, such as, GPs, community health, social care and the police. The CCG was drafting the overall plan and they would monitor subsequent activity relating to this group of patients and re audit.
- All information from audits were discussed in regular staff meetings and we saw evidence of this. The department also had a newsletter to share information with all ED staff.

Competent staff

- Staff within the ED had the right qualifications, skills and knowledge to carry out their roles.
- Nursing staff were in the process of having to revalidate this year. They were supported by their team leaders, and the head of nursing with this new change in how they maintain professional registration.
- The department leaders told us that they received time for their regular one-to-one meetings and appraisals, and were given time for meetings to reflect and plan the service. The head of nursing for the ED met with the chief nurse every month for a one-to-one, and the deputy chief nurse. This had improved since the last inspection as, the ED leads did not have protected time in order to plan. This was observed to have been actioned.
- The triage area and the resuscitation room were always staffed with appropriately trained staff, with the relevant courses and skills.

- Nine nurses had completed an emergency department module. They were sharing what they had learned with the rest of the ED team, using posters to display information such as, sepsis, dementia, national early warning scores (NEWS), improving communication in the ED, and initial assessment of the febrile (high temperature) child. We saw these posters and they were to be displayed in the department for all staff and patients/relatives to see. Another 15 nurses were currently undertaking a selection of courses such as, non-medical prescribing, emergency nurse practitioner course and a module in the deteriorating patient.
- Trainee medical staff in the department told us that they were given protected time to attend training and were supported by the senior ED doctors to develop.
- The head of nursing for ED told us that she would work in the department to release nursing staff to complete task such as, e-learning (intranet learning courses) or internal teaching courses.
- We spoke with staff that had recently joined the department and they had received a department specific supernumerary induction, and had appraisals at six months. They were allocated a mentor and a competency booklet.
- A newly appointed paediatric band 7 (senior sister) had taken on the role of teaching the adult nurses. This was specific skills in treating and understanding the paediatric patient. This had received positive feedback.
- Data provided by the trust showed that 86% of ED staff had received an appraisal within the last 12 months. This met the trust's target. We were not given a breakdown of nursing, medical or non-clinical staff. However, this had significantly improved since their last inspection in October 2014, which was 66%.
- The department's nurse training programme has improved since the professional development nurse had been in post. One member of staff had been given the opportunity to take part in an infectious diseases course abroad.
- ED board round meetings twice a day were used to provide educational teaching for junior staff.

Multidisciplinary working

- Communication between staff was witnessed to be effective. Particularly good interactions were observed among the nursing and medical team.
- The department implemented internal debrief sessions for particularly traumatic cases, for all members of staff involved, clinical and non-clinical. One of these sessions had been carried out recently and staff gave positive feedback and felt supported.
- We saw the hospital stroke nurse visit the department, checking for any newly arrived patients. The matron for medicine was reviewing the condition of six medical patients waiting to be admitted.
- When the department had numerous patients waiting for medical admission, the hospital's acute physician would carry out a ward round on these patients.
- The acute oncology service provided daily 'flagging' of urgent oncology admissions via the ED. This system identified patients needing admission as an emergency.
- Adult and child mental health services were available upon referral. Staff told us that adult patients were seen promptly by the psychiatric liaison team; however, these patients could be waiting for periods of time on the observation unit if they needed to be admitted to a psychiatric bed. The child and adolescent mental health service (CAHMS) visited the department to assess patients if they were medically fit. Staff told us patients that were referred out of hours could have a long wait, but this had improved now. If the patients had any medical concerns they were admitted to the children's ward and they would be followed up. This service had improved following an action from the last inspection, to work with the commissioners to ensure that the CAHMS were providing a consistently responsive service and the staff had seen an improvement.
- The department had access to a private service who provided recovery and treatment services for patients struggling with alcohol and drug misuse. Patients who were referred during the day would be seen in the department if needed.

Seven-day services

- The ED was accessible 24 hours a day, seven days a week. During this time the department had access to x-ray and computed tomography (CT).
- The rapid assessment intervention team (RAIT) team were available Monday to Friday 9am to 9pm and at weekends 9am to 5pm.
- The department's consultant cover was the same as weekdays.

- There was appropriate access to pharmacy and arrangements in place for emergency general surgery and critical care.

Access to information

- Information needed to deliver effective care and treatment was available to staff in a timely and accessible way.
- The department had an electronic system where they could look at patients previous notes, including allergy statuses.
- When patients moved between teams or wards the appropriate information was shared. The department had separate records if the patient was referred to the medical speciality.
- All pathways and risk assessments were scanned onto the ED system, which meant they could then go with the patient to the relevant ward.
- The trust used the Situation Background Assessment Recommendation (SBAR) template for handovers. This ensured no important clinical information was missed.
- Locum doctors were given their own password for access to the EDs electronic systems so patient information was readily accessible. However, during our unannounced visit, we spoke with a locum consultant, who had no password and was not able to access the trust's electronic patient information systems. This meant there was a risk of delays in accessing patients' blood results, and using the electronic prescribing system due to having to rely on other members of the medical staff to access the system. This could have resulted in increased waiting time for the patients. However, we did not see any delay during our inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All nursing and medical staff we spoke with demonstrated a good knowledge of the key aspects of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards and understood how it related to the care they gave. Staff told us these topics were covered in their trust mandatory training and safeguarding training. The percentage of medical staff who had completed training in this subject was 81% and 90% of nursing staff. There was a specific section in the adult admission assessment booklet to complete the patient's capacity status.
- The paediatric trained staff were aware of the key elements of Gillick and Fraser competencies (which are national guidelines for assessing how patients under 16 can make informed decisions). They could advise and assist staff who were less aware.
- We observed good practice around staff gaining consent, to give patient information to relatives or friends, that telephoned the department. A patient was asked if it was ok to inform their relative about the patient's current progress in the ED, and a password code was asked for prior to giving the daughter the information.
- We witnessed several examples of staff asking for patients' permission before undertaking clinical interventions. However, this was not always documented formally in patient records.

Are urgent and emergency services caring?

Good

We rated the service as good for caring because:

- Staff showed compassion towards patients and their families
- Patients told us they had been treated with kindness, dignity and respect.
- Privacy and dignity was generally respected whilst patients were being cared for within the department by the nurses and doctors.
- There were good support systems in place to help people emotionally and after a loss of a loved one.

However, we found that:

- Some patients' privacy was not respected by staff when booking in at the reception desk when the department was busy.

Compassionate care

- Reception staff were generally respectful, polite and compassionate to patients. We observed a patient booking in at the desk who was showing signs of discomfort, so the receptionist told them to take a seat and they got the relevant information they needed from the relative.

Urgent and emergency services

- We spoke with 10 patients who were very happy with the care they received in the department. Patients who had visited the department in previous months told us they were seen much quicker this time than previously. They said they were seen from 10 minutes of booking in, then a 20 minute wait to see a doctor or a nurse practitioner.
- We observed staff introducing themselves to patients and relatives. This is line with the trusts 'hello my name is' policy. Staff would ask the patient how they would like to be addressed. All interactions were observed to be caring and respectful.
- We saw that staff ensured that each patient had access to a call bell. We observed all patients had a call bell to hand, and when they were used, the staff response was very quick and respectful. This was seen to be an improvement since the last inspection in October 2014.
- Privacy and dignity was maintained during all interactions and assessment with patients in all clinical areas. All staff showed an awareness of respecting their patient's privacy and dignity by closing curtains around all bays. This had improved since the last inspection.
- Patients at the reception desk were not always given the option of discussing their presenting complaint in a confidential manner by staff or in an area where they could not be overheard. This had been raised at the previous inspection in October 2014. We also observed patient confidential information being clearly discussed between staff, and visiting police officers when speaking to patients in the reception area. The trust had a separate room for private conversations, but this was not used during our inspection. We raised this as a concern with the trust, who took actions to address this. These included including playing ambient noise into the waiting room and placing confidentiality posters at the desk, with a clear 'red' area marked on the floor to ensure nobody stood behind the person booking in.
- The Friends and Family Test (FFT) is a method used to assess patients' perceptions of the care they received and how likely they would be to recommend the service to their friends and family. From September 2015 to March 2016, the percentage of patients that would recommend the department was between 90% and 98%. The average response rate between these months was 8% of all discharged patients. The trust recognised this as a poor response rate and since March 2016 had implemented a different survey with fewer questions to improve response rates from patients
- The department now gained feedback using an independent company. They asked if patients were given enough privacy when being examined; the department scored eight and a half out of 10. This was in line with other trusts.
- The department also had a plan for a computer tablet to be used in minors to gain patient feedback.

Understanding and involvement of patients and those close to them

- All patients we spoke with told us they were informed of their treatment plan and potential diagnosis throughout their visit.
- Patients said doctors and nurses kept them informed of what was happening during their time within the ED.
- Relatives felt welcome and were able to sit with their family member. They were kept informed if the patient consented.

Emotional support

- The staff in the department had good working relationship with the bereavement service. The bereavement team would follow up any family that had experienced loss.
- Staff were able to signpost patients to relevant external organisations for support when required.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good

Overall, we rated the service as good for responsiveness because:

- Between April 2016 and June 2016, the department was meeting the target of 95% of all patients to be admitted, transferred or discharged home within four hours of arrival to the emergency department (ED) each month.
- Pathways were in place to improve flow in the department, including the use of an ambulatory care pathway and the opening of the Rapid Assessment Hub.
- Patient flow in the department had improved significantly since the last inspection.

- The ED senior team had an effective working relationship with the site management team, enabling rapid decision-making regarding patient flow in the department.
- There was an easy process for people to complain or raise a concern. There was openness and transparency in how complaints were dealt with.
- Individual needs of patients were identified and met.
- We saw robust planning and service delivery designed to support people with complex needs

However we also found:

- Seating was not always sufficient in the adult or children's waiting rooms when the department was busy.

Service planning and delivery to meet the needs of local people

- The emergency department (ED) was open 24 hours a day, seven days a week. There were separate areas for adult majors and minors, and paediatric majors and minors.
- Planning for service delivery was made in conjunction with a number of external providers, commissioners and local authorities to meet the needs of the local people. For example, recent meetings discussed providing a single point of access for emergency care within the hospital site. This would reduce any confusion for visitors as to which service is most appropriate for their needs.
- The department worked closely with social services and substance misuse service in developing care for patients with specific needs. Known risks were identified and managed appropriately to ensure referral to these external services was effective and timely.
- The department provided the relevant consultancy cover seven days a week as recommended by the Royal College of Emergency Medicine (RCEM) guidelines.
- Seating, within both adult waiting room and the children's waiting room, could become crowded during busy times. This was observed during our inspection. Senior members of the team told us this would improve when the new urgent care centre opens adjacent to the department, which would include a large waiting area.
- Patients told us that they found the layout of the ED confusing, there were no clear signs for the minor's area or the exit and patients were seen to be wandering looking for the way out. There were two clear signs outside for the main entrance and the ambulance entrance. The ambulance entrance was only accessible with a card swipe access.

Meeting people's individual needs

- Services were delivered in a way that took into account the needs of different people, in relation to age, gender, religion and disabilities. The department would make reasonable adjustments to accommodate patients when receiving care and treatment.
- Where patients had complex needs, such as living with dementia or learning disabilities, the patient would be managed in a way that took into account their individual needs. Staff told us they would try to ensure the patient was seen by as few members as staff as possible, with a minimal wait. They would ensure a quiet cubicle was available and encourage the patient's carers and relatives to be present.
- The department had nurse lead for dementia within the department. They had plans to have a separate area in ED for patients with dementia to be treated, and they would carry out teaching sessions for the other staff. The department showed us they are always looking for ways to improve this service. The ED used the trust's dementia care process, including the use of 'This is Me' booklets which gave clear details about patient's individual needs, likes and dislikes.
- Learning disability nurses were available if required. They were from a local community health trust but ED staff said they were accessible when needed.
- The department used a care plan document called 'we care around the clock'. This ensured that patients were asked every two hours if they needed the toilet, if they were in any pain or discomfort and to make sure they could reach their drink and call bell. This also had a chart to document if the patient had been repositioned on their trolley, or bed if had been in the department longer than six hours. We observed this being used during our inspection.
- Where a patient's first language was not English, the department was able to provide telephone translation or book an interpreter to visit the department. We were told that staff discouraged the use of a family member to translate; this was to ensure information from the patient's was accurate and confidentiality was

maintained as much as possible. As part of the nursing assessment booklet there was a section relating to communication needs, and if an interpreter was required.
- Patient information and advice leaflets were not available in other languages. If required, there was a phone number and website on the back of leaflets for staff to print off in different languages. This process had been implemented following the last inspection in October 2014.
- Staff had access to a range of appropriate leaflets for a variety of support services in the community, which they could give to patients and relatives if required.
- Information in relation to domestic abuse was readily available within the department, along with the ability to refer patients to an external provider. There was also information in relation to female genital mutilation and what processes to follow.
- The paediatric area was decorated in child friendly colours, with toys and a television available. There was also a refreshment table with squash and water made readily available.
- During our inspection, we observed a sealed box with a care plan and specific medications in for a patient who attended the department frequently. The patient required specific medications that are not stored as regular stock in the ED. With a pharmacist, they made a designated pack up for the patient, which meant if they arrived out of hours they had the medications ready to give causing no delay in treatment.
- The department had bereavement folders to provide to families where their relative had died. There were versions relevant to both adult and paediatric patients. These folders provided all the necessary information that people might have following a death, and provided them with contact details of numerous organisations to support them during bereavement.
- The waiting room had two vending machines for patient and relatives use with healthy options available. Hot food was available in the department, with a variety of choices. Sandwiches were also offered.
- Out of 10 patients we spoke to, one was not offered a drink. However, they explained they had not long arrived and they were aware of where to get a drink from the ED's 'hydration station'.
- We observed a volunteer working in the department during our visit; she was witnessed to be providing hot drinks rounds for patients and relatives.
- In the observation unit patients are often in overnight so they would be offered breakfast in the morning, and always hot meals for lunch and dinner. We observed jugs of water on patient tables that were all in within easy reach.
- The reception desk had no segregation between the two receptionists booking patients in. This meant that when two receptionists were both booking in patients, patients could hear confidential information about other patients. There was signage and a yellow line in front of the reception desks for people to stand behind whilst waiting to see reception staff, but on most occasions, visitors to the ED did not wait behind this line and could therefore overhear patient confidential information being discussed at the reception desk.
- A private room was available for those with a relative or friend who was critically unwell. We didn't observe this room being used whilst we were in the department, but on observation it was quiet and away from the main area of ED with comfortable seating.
- A chaplaincy service was available for all religions where required.
- Staff reported positive relations with the local mental health providers and that assessments were carried out in a timely fashion.

Access and flow

- The Department of Health target for EDs is to admit, transfer or discharge 95% of patients within four hours of arrival at ED. The department had met the 95% standard since April 2016. This had improved significantly since their last inspection in October 2014.
- The total time spent in the department was consistent with the England average since February 2016. This had improved since the last inspection.
- The percentage of emergency admissions via ED waiting four to 12 hours from the decision to admit had been higher than the England average; however, this had reduced since April 2016. In May 2016, only 7% of all emergency admissions waited four to 12 hours to be admitted, which was better than the England average. No patients had waited over 12 hours for admission.
- The trust told us that the reason for being lower than the England average in admissions was due to the introduction of an 'EPIC' (Emergency Physician-in-Charge) Clinician. The EPIC clinician, along with the nurse-in-charge and patient tracking staff (called the ED tracker) oversaw flow in the department

as well assisting the middle grade and junior staff with clinical decision-making and procedures. A consultant carried out this function for sixteen hours per day whilst a middle grade doctor took on the role overnight.

- The EPIC clinician's role was to advise and coordinate the ED doctors, ensure timely and safe assessment, treatment of patients. They also would facilitate referrals to specialities and expedite radiology and pathology requests. The EPIC clinician would liaise with the nurse in charge regularly and if there were delays in admitting their referred patients to the wards, they would attend the bed management meetings and help develop plans.
- The nurse in charge had an overview of all areas within the ED. They would work with the ED tracker, whose role was to liaise with the bed manager and the wards to expedite patient transfers. The tracker would chase up specialist doctors who had not seen their patients in the required timeframe.
- The department's escalation plan had the roles of the EPIC consultant, nurse in charge and the tracker. This gave clear guidance for all staff roles and escalation procedures. This meant it was clear whose role it was to escalate delays within the department and manage them appropriately.
- We observed the department to be supported by the trust's site management team to manage patient flow. They were present liaising with the nurse in charge and tracker regularly during our inspection.
- The ED used an electronic system to visually see how many patients were in the department, number of patients waiting to be seen and who was waiting for a bed. This was a good visual aid to ensure safe tracking of patients and that they could be treated in a timely way. The site managers also knew how to use this system.
- The ED had dedicated board rounds at least twice a day to discuss all the cases in the department with the focus on capacity, demand, and patient flow in the ED.
- The ED had an excellent relationship with the radiology department which regularly facilitated same-day ultrasounds and CT scans assisting with prompt diagnosis and outpatient care if applicable.
- The department had newly developed pathways, for example, renal colic and bleeding in early pregnancy to ensure optimal care often without the use of an inpatient bed with an easy-to-access clinical pathways on the trust's computer systems.
- The department had the option to transfer suitable patients to the ambulatory emergency care unit, which improved patient flow and assessments.
- The proportion of patients leaving before being seen was slightly better than the England average. In February 2016, 3% of patients left the department before being seen compared to the England average of 3.2%.
- The median time in the ED for June 2016 was 255 (2 hours and 35 minutes in the department) and 159 in July 2016 (2 hours and 39 minutes in the department), which was still just above the England average but represented a significant improvement for the ED from the previous year.
- In March 2016, there were 137 black breaches at this trust, where handovers from ambulance arrival to the patient being handed over to the ED took longer than 60 minutes. Staff told us that since March, which was a very busy time, no further breaches had occurred. During our inspection, we observed no ambulance waiting longer than five minutes to handover the patient to the ED staff.
- The department's statistics for initial time to clinical triage, for ambulance patients, had improved since the introduction of the rapid assessment hub. This had four cubicles and was staffed by a senior nurse, two health care assistants (HCAs), who were trained in phlebotomy (the taking of patients' blood for testing) and cannulation (the insertion of an intravenous needle to administer intravenous medicines). They had access to the ED consultant for x-ray requests, prescribing medications and to immediately assess patients of concern.
- We observed the nurse taking handovers from the ambulance staff. The patients were quickly assessed, had observations, electrocardiograms (ECGs) if needed and bloods taken and given any prescribed medication as needed. Then they were moved to other areas within the department depending on their triage category. This meant that if there was a long wait to be seen in the major's area, the patients had received the appropriate tests before seeing the medical staff, thus enabling earlier clinical decision-making about treatment options.
- Since March 2016, all patients who had been referred straight to the medical speciality were seen directly on the acute medical unit, and not in the ED. This meant increased capacity within the department and was part of an emergency ambulatory care pathway.

Urgent and emergency services

- During the inspection, we observed the flow of patients self-presenting at reception. These patients were booked in then assessed by an experienced nurse who decided which area of the department they needed. Children were directed straight round to the separate paediatric area within the department. Adult patients with minor injuries would wait in the main waiting room, until a doctor or an emergency nurse practitioner would call them trough. Patients told us the reception staff informed them of the waiting time.
- The observation unit formed part of the ED. The unit contained seven beds, with a separation for male and female areas. Patients who were transferred from the main department into the unit included those waiting for transport, referred to the rapid assessment intervention team (RAIT), awaiting blood results, or those requiring further observation post head injuries and intoxicated patients. Staff told us sometimes there would be patients in the observation unit who were waiting for a bed on the speciality wards, which would stop flow. During our inspection, there was capacity in the observation unit for the main department to flow into.
- During our unannounced visit at 7.30pm there were 31 patients in the department they had had 197 attendances since midnight. No patient had waited in the department for over four hours. There were three patients who had been in the department for between three and four hours, the nurse in charge told us they all had plans in place to be transferred to a ward or discharged before the four hours. This was checked and all patients had been discharged under the four hour target. There had been no four breaches for the previous two days.
- A rapid assessment intervention team (called RAIT) was available when necessary. This team provided assessment, care panning and therapy to rehabilitate and promote independence in the patient's own home, or in an intermediate care setting. RAIT is a multi-disciplinary team of physiotherapists, occupational therapists, nurses, speech and language therapists and rehabilitation assistants. They saw patients on the observation unit to support early discharge and avoid a hospital admission.

Learning from complaints and concerns

- There was clear guidance on display in the ED for those using the service to make a complaint or express their concerns. Reception and nursing staff knew what steps to take should a patient or relative ask them how to make a complaint.
- The department had received 49 complaints from January 2016 to June 2016. They had all been actioned and responded to in a timely manner in accordance with trust policy.
- Within meeting minutes for the ED clinical improvement group, we saw evidence of complaints being discussed. Any necessary actions or learning points relating to complaints were addressed during these meeting.
- We saw evidence of people who used the service had been given written apologies. The head of nursing for ED and assistant operational manager had also personally met with complainants to apologise.

Are urgent and emergency services well-led?

Good

Overall, we rated the service as good for well-led because:

- The leadership team had significantly improved the department's performance in meeting the four hour target to improve safety in seeing and assessing patients. The department leaders had implemented a range of systems and processes to drive improvements throughout the service.
- Feedback from staff relating to recent changes in nursing leadership was positive, with changes being welcomed to improve patient care in the department. The department had designed their own patient values and staff standards. These were displayed in all clinical areas and staff knew about them.
- There was a generally robust governance system in place to monitor safety and risks in the ED. Quality of care was discussed in monthly ED meetings with the consultant and nursing teams.
- There was an open and inclusive culture within the department and staff enjoyed working within the ED. Leaders were visible, approachable and encouraged a culture of transparency and openness. This had improved morale and had improved since the last inspection.

However, we also found that:

- Not all staff were fully aware of the department's strategy for moving forward with the urgent care centre plan.
- Some risks that were found on our inspection had not been identified by the leadership team such as the security of the children's' ED. Once we escalated this concern, the leadership team took immediate actions to address this concern.

Vision and strategy for this service

- The trust's vision and values were displayed in the waiting room and staff at all levels knew about them.
- The emergency department had developed their own separate standards and values for both patients and staff. These were developed as a team and were displayed in all areas of the department, including the patient cubicles. They were based on the five domains of the Care Quality Commission, safe, effective, caring, responsive and well led. The head of nursing for the ED told us they were waiting for the trust's patient experience team to audit these standards, and that this would enable the department to monitor the quality of these standards and make improvements as needed.
- The trust had commissioned a strategic outline to develop a single point of access for urgent and emergency care. An urgent care centre was part of this strategic direction and had been approved by local commissioners. The department was currently waiting on a time frame for the opening of this new service.
- The department worked on a specific vision for the department to maintain flow and to assess, treat and decide an outcome plan for all patients within four hours.

Governance, risk management and quality measurement

- There was generally a robust governance system in place to monitor safety and risks in the ED. Monthly meetings were held and staff from all levels were invited so that learning from incidents and complaints could be shared effectively and quickly.
- Within meeting minutes was saw evidence that all serious incidents, staffing vacancies, performance and complaints were discussed and actions plans to make improvements put in place where required.
- The risks present on the departmental risk register generally reflected the views of the staff we spoke to at all levels. The top risk was the reduced flow out of the department, meaning an overcrowded department at times of pressure. A risk register is a management tool used in risk management and compliance within a department, identifying all risk recognised by the organisation, each risk is given a priority scoring and recommended measures.
- The department leaders had implemented a range of systems and processes to drive improvements throughout the service for safety and quality of the care and treatment provided, however, some risks were found on our inspection that had not been identified by the leadership team. For example, such as the security of the children's ED, the lack of an appropriate mental health assessment room and resuscitation equipment. Once we escalated these concerns, the leadership team took immediate actions to address this concern by making the mental room facilities safe, reviewed the security systems for children's ED and ensured all required equipment was available.
- The department had a clear plan in improving key specific areas such as sepsis treatment. This was shown by the implementation of a sepsis proforma assessment tool that was now being used within the department.
- The ED quality and safety dashboard was used to measure and monitor quality and safety performance on a monthly basis. This was also used as a basis for clinical governance meetings with the focus on continuous improvement for the service.
- The clinical leaders explained that the ED four hour target was not just the ED's responsibility but the whole hospital had a role to play in ensuring patients had high quality and timely care within the department. They felt that this has helped them to meet their targets.
- A monthly clinical governance meeting well attended by staff from all disciplines and levels where problems were discussed and improvement action plans were made.

Leadership of service

- The department was led by a head nurse for ED, who was appointed in June 2015, an operational assistant and a clinical lead consultant. There was a clear management structure with a well-established and consistent leadership team since the last inspection.

- The leadership team had significantly improved the department's performance in meeting the four hour target to improve safety in seeing and assessing patients.
- The department were proud of their new head of nursing, and staff told us the department had seen many improvements made since their appointment.
- We saw clear evidence of leaders for this service working closely with their team to develop their service and encouraging junior staff to contribute.
- Leaders of the service described that they were supported for their own learning needs and appraisals. The head of nursing had monthly one to ones with the chief nurse for the trust, and the deputy chief nurse.
- At times when the department experienced high patient volume, we were told by staff that leaders were visible and worked as part of the team to maintain patient flow; this practice was observed during our inspection.
- All staff we spoke to said that leaders were approachable and visible and they felt confident they could voice concerns openly and would be listened to. Since the head of nursing for ED had been in post, they had started weekly 'drop in sessions', where staff could book an allocated time slot to discuss any concerns or ideas for improvement.
- The department leaders would hold debrief sessions for the staff who had been involved in a traumatic patient experience. They would discuss what went well and how they could improve and general support for staff who were involved in an emotional patient case.
- There was also a counselling service staff could access through occupational health, or a private company provided counselling services should staff need them.
- Staff told us that there could be more communication from the trust's executive leadership team. We spoke with a group of band 7 senior sisters, who told us they would more regular communication regarding the opening of the urgent care centre and single point of access plan.

Culture within the service

- All staff we spoke to told us there was a positive teamwork approach in the department. New members of staff had particularly noticed the close working relationships within the whole clinical team. This made communication and day-to-day practices more efficient for the patient.
- Staff we spoke to said they felt valued and respected and the junior nurses had great respect for their leaders and band 7 team.
- The department had gone through extreme demand on their service in 2013/2014; however in the last 12 months staff told us they felt there had been improvements within the department, and also an improvement in staff morale.
- We spoke with three newly qualified nursing staff. They had all been students in the department during their training and because of the friendly, team approach to working they wanted to start their careers within this ED.
- Staff at all levels also told us that although achieving targets was important they would not be afraid of breaching a target if a patient still required ongoing care and treatment before being discharged or transferred to the relevant ward.

Public engagement

- Patients and relatives were given the opportunity to provide feedback through the Friends and Family Test (FFT) comment cards in the department. These were situated throughout the department.
- The department had commissioned and was taking part in another survey to gain a deeper understanding of patient feedback. This was going to replace the original (FFT) cards, as the public will also be able to provide feedback including text messaging and using computer tablets in the department. This meant, patients would have more options to feedback and would increase the amount of feedback they receive.
- The trust used social media to communicate with its population, and this included information regarding the ED and health promotion to prevent attendances. The public could also comment and give feedback using this method.

Staff engagement

- Staff told us within the last 12 months they were encouraged to share experiences and comment on ideas for improvement. This could be done by booking a session with the head of nursing during the 'drop in sessions'.
- Senior staff told us it was difficult to organise regular meetings for all ED staff, due to having to provide adequate rostered cover. They provided a monthly newsletter, and would have information learning points shared at handovers.

- During our inspection, the band 7 senior sisters attended an 'away day'. This was a chance for them to share ideas for improvements within the department and have some internal teaching sessions. We observed part of this and they were having a session with the hospital pharmacist to start training on Patients Group Directives (PGDs), which would enable nurses to provide prescription only medication to groups of patients.
- This 'away day' was part of the head of nursing's plan, for ideas and improvements to come from the staff who worked in the department daily.

Innovation, improvement and sustainability

- The leadership team had significantly improved the department's performance in meeting the four hour target to improve safety in seeing and assessing patients. During an interview with the clinical lead consultant and the head of nursing, they displayed a thorough understanding of the improvements that were needed to strengthen the quality of their service. The lead consultant was proud of many of the improvements the department had made in the last 12 months.
- Improvements included, increasing their establishment of middle grade doctors, development of the rapid assessment hub, well attended clinical governance meetings, improved incident reporting turnaround, and updated computer system which allowed simpler and faster tracking and discharging of patients and new clinical pathways and protocols. One of these new documents was the emergency department referral to specialities protocol. This meant that the junior doctors had a clear process in what conditions to refer and to whom.
- One simple improvement the staff liked was, taking out a large desk area in the middle of the major's area. The area was more spacious and patients didn't over hear conversations made by staff that would sit and use the telephones. This also meant a busy department felt calmer with a quiet atmosphere.
- Leaders informed us of future changes they wished to make in the department including admitting rights to medicine and surgery; this had been discussed with proposals for change, but nothing had been agreed on at time of inspection. They had a plan to recruit and train internally more emergency nurse practitioners (ENPs); to have a nurse led minors area. This would mean more doctors being available to see patients in the majors and paediatric area.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Milton Keynes University Hospital NHS Foundation Trust provides medical care at Milton Keynes University Hospital. There are 10 medical inpatient wards, with 297 beds in total, including one ward designated as a medical assessment unit and one ward designated as a short stay ward. There were 26,612 admissions to the service in 2015. The medical service included a number of different specialities including general medicine, cardiology, respiratory medicine and stroke care. The service also had an endoscopy unit, oncology suite, ambulatory care unit and a patient discharge unit. The hospital did not provide a 24 hour stroke thrombolysis service (this is a treatment where drugs are given rapidly to dissolve blood clots in the brain) as this was provided by another local NHS trust.

We carried out a focused unannounced inspection on 12 and 13 July 2016 following our previous comprehensive inspection in October 2014. During the previous inspection, we found that medical care overall required improvement and that specifically, the key questions of safe, effective and responsive required improvement.

During this inspection, we visited nine wards; ward 1; the medical assessment unit, ward 2; the short stay unit, ward 3; general medicine, ward 7; stroke, ward 8; general medicine and gastroenterology, ward 15; respiratory, ward 16; respiratory, ward 17; cardiology and the catheterisation laboratory; and ward 22: haematology. We also visited the patient discharge unit.

We spoke to 10 patients and 25 staff including health care assistants, domestics, nurses, junior doctors, consultants and allied health professionals. We observed how care and treatment was provided and we looked at the records of 20 patients. Before the inspection, we reviewed performance information about the trust. During this inspection, we inspected all five key questions: safe, effective, caring, responsive and well-led.

Medical care (including older people's care)

Summary of findings

Overall, we rated medical care at this hospital to be good because:

- The Hospital Standardised Mortality ratio (HSMR) was significantly better the expected rate and generally outcomes for patients were positive.
- Staff understood their responsibilities to raise concerns and report incidents and near misses and learning from incidents was used to drive improvements across the service.
- Infection prevention and control was generally robust, with staff adhering to the infection control policy.
- All equipment viewed was in service date, and had been maintained or electrically safety tested and was fit for use.
- Records were kept securely and were completed appropriately.
- Risks to patients were identified and escalated appropriately.
- Nurse staffing levels were appropriate, with staff flexed to cover vacancies.
- Patients generally had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. Risks to patients were identified and escalated appropriately.
- Staff generally had a good understanding of the Mental Capacity Act and consent to care.
- Patients received compassionate care, and patients were treated with dignity and respect. We saw that staff interactions with patients were person-centred and unhurried. Staff were focused on the needs of patients and improving services.
- Whilst bed occupancy was very high, at 97%, above the threshold of 90%, patient flow was generally effective in the service.
- The service performed well for referral to treatment times; scoring 97% across the medical specialities.
- Services met patients' needs, especially those living with dementia.
- Local ward leadership was good and ward leaders were visible and respected.
- There was a positive culture across the medical wards with staff telling us they enjoyed working at the trust. Morale was high across teams.

However, we also found that:

- Across a number of wards, we found resuscitation trolleys were not checked consistently. On inspection, we found where they had been checked, equipment and some medicine inside the trolleys were found to be out of date. We raised this as a concern and the trust took immediate action to address this by reviewing all resuscitation trolleys and ensured that ward leaders were accountable for these checks.
- Induction of agency staff was not always robust as some wards did not follow the trust's policy for agency staff induction and we founds some wards were not keeping any records of these inductions.
- We found that medicines were not always stored securely or safely on wards 15 and 16.
- The non-invasive ventilation policy was out of date and had not been reviewed. New guidance relating to this had been released in March 2016, which meant there was a risk that staff were not following current guidelines. The service was aware that it was out of date and was planning to review this; however, there was no time scale for this.
- Not all patients were routinely being transferred or discharged from AMU within 72 hours of admission, though the service had reduced the number of patients with longer than planned stays from April to July 2016. The service did not have an action plan to improve their performance. We were advised that this had recently been added to the trust's transformation work streams.
- Whilst the risk register generally reflected the wards' safety and quality of care and treatment, we did find some risks were not recorded on the service's risk register.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Overall, we rated this service as requiring improvement for safety because:

- Across a number of wards, we found resuscitation trolleys were not checked consistently. On inspection, we found where they had been checked, equipment and some medicine inside the trolleys were found to be out of date. We raised this as a concern and the trust took immediate action to address this by reviewing all resuscitation trolleys and ensured that ward leaders were accountable for these checks.
- Induction of agency staff was not always robust as some wards did not follow the trust's policy for agency staff induction and we founds some wards were not keeping any records of these inductions.
- Hazardous chemicals and needles were not always kept in secure locked rooms.
- We found that medicines were not always stored securely or safely on wards 15 and 16.

However, we also found that:

- Risks to patients were identified and escalated appropriately, with good use of the National Early Warning Score (NEWS).
- Staff understood their responsibilities to safeguard patients from harm.
- Nurse staffing levels were appropriate, with staff flexed to cover vacancies.
- Medical staff cover was effective with appropriate arrangements for out of hours.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. We spoke to staff who explained the trust's electronic incident reporting system and how they would use to report incidents. The ward sisters received a copy of all incident reports and that they investigated these incidents where appropriate. Staff received feedback from incidents and learning was shared through team meetings and ward newsletters.
- There were no never events for medicine recorded between 1 June 2015 and 31 May 2016 within medicine. A never event is a serious incident that is wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between 1 June 2015 and 31 May 2016, 17 serious incidents were reported within medicine, including six falls and three pressure ulcers. In 2015, there were 1132 incidents in total. The main themes of these were; patient falls (278 incidents), community acquired pressure ulcers: where the pressure ulcer developed before admission to the service (232) and medication incidents (91). We saw evidence of 72-hour executive summaries and root cause analysis report following patient falls on wards 14 and 17. The reports were thorough, methodical and involved speaking to staff and other patients. We also saw that they had been reported appropriately through the trust's electronic reporting system.
- We saw evidence that lessons were learned, and action was taken as a result of investigations when things went wrong. Staff gave us three examples of changes that had been made as a result of incidents occurring within the department. One of these was the introduction of the World Health Organisation (WHO) safety checklist in coronary care. Further examples were the development of a new standard operating procedure detailing the process to be followed in the event of a failed cannulation and spot checking blood units as a result units of blood previously being wasted.
- We saw that lessons were shared to make sure action was taken to improve safety. Several wards produced newsletters to ensure lessons were shared, with one ward; ward 7, having a read and sign policy to ensure all staff had read it.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

- Patients who used services were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. Staff explained that they apologised to patients and showed an awareness of the duty of candour.
- When things went wrong, thorough and robust reviews or investigations were carried out. All relevant staff and patients who used services were involved in the review or investigation.
- Mortality and morbidity meetings were held monthly which covered any incidents, near misses and deaths. We reviewed the minutes of the meetings held in February, March, April and June 2016. The minutes showed that the meetings included doctors of all levels and that they provided learning from incidents and safety alert updates.

Safety thermometer

- The NHS safety thermometer is a monthly audit of avoidable harms which included new pressure ulcers, catheter urinary tract infections and falls.
- Each ward we visited displayed safety thermometer information in the ward corridors.
- 30 new hospital acquired pressure ulcers were reported in the medicine safety thermometer between April 2015 and April 2016, with variable rates throughout the year. During the same period, there were 17 falls and three catheter acquired urinary tract infections. We saw that patients at risk of falls were wearing anti-slip socks to reduce their risk of falls and falls prevention leaflets were given to patients. We also saw that pressure ulcer assessments were done, and patients were repositioned to reduce the risk of developing pressure ulcers.
- The senior sisters on the wards explained their ward's results and the actions they took to improve their performance. For example on AMU, the senior sister told us that they were scoring poorly on completing fluid balance charts totals. She told us that as a result she had implemented four hourly totalling, to save time at the end of the day. We were told that this had led to improvements in calculating total scores. We reviewed the service's fluid balance chart and policy and saw that there was a box for inputting four hourly totals and that the policy guidance stated that cumulative totalling should be done every four hours as a minimum.
- We were told on ward 7 that they had reduced the number of catheter acquired urinary tract infections, as they did not catheterise purely for physical incontinence. The ward had a bladder scanner on the ward and they used other methods first to deal with incontinence if the patient was able to do so. We were told they only catheterised patients if other methods to deal with incontinence were unsuitable.

Cleanliness, infection control and hygiene

- Effective standards of cleanliness and hygiene were generally maintained within the service. We saw that the ward areas were visibly clean and that staff adhered to the dress code, which was to be 'bare below the elbow'. This means that staff did not have clothing or jewellery below their elbows to reduce the risk of spreading infection. We also saw bathrooms and toilets being cleaned during our inspection by in-house domestic staff and that staff used hand sanitizer before and after contact with patients. We reviewed the service's hand hygiene audits from April 2015 to March 2016 and saw that medical wards were compliant with hand hygiene protocols during this period.
- Across the service, 87% of staff had received training in infection prevention and control, which was slightly below the service's target of 90%.
- We saw bay curtains were changed regularly and dated so that staff would know when they needed to be changed. We saw equipment had dated 'I am clean' stickers so staff could tell when equipment was last cleaned.
- . On ward 7, we observed that the majority of beds did not have hand sanitizers, and that the nearest sanitizers were at the nursing station. We also saw one patient on one ward 8 had an empty hand sanitizer dispenser at their bedspace and they told us they had been using their neighbour's. We saw that staff used other available hand sanitizers when caring for these patients.
- We reviewed the hand hygiene audits for ward 7 and saw that they had been found compliant with hand hygiene protocols every month between April 2015 and March 2016, with the exception of October 2015 when they were not audited. We saw additional hand hygiene audits that showed that ward 7 were also compliant with hand hygiene protocols in April and May 2016. Therefore, there is no evidence to suggest that the lack of hand sanitizers available at the bedside on ward 7 was impacting on hand hygiene or patient safety.
- Reliable systems were generally in place to prevent and protect people from a healthcare-associated infection. We saw patients with infections were nursed in isolation

side rooms with appropriate signage displayed to reduce the risk of spreading infection. There were gown and glove stations near to all side rooms to ensure that both patients and staff were protected. However, there were no isolation facilities on cardiology ward 17 for patients with infections. The ward had had a breakout of norovirus in January 2016, leading to the ward being closed for 10 days. We reviewed the serious incident report in relation to this and saw that due to the lack of isolation facilities within the ward, a highly vulnerable patient had to be moved onto a different ward to minimise the risk of infection. In cases where cardiac patients needed isolation rooms, they were transferred from ward 17 to ward 15 or 16: which were respiratory wards.

- Screening for MRSA carriage was done on admission. This was checked on handover, and if this had not occurred when the patient came onto the medical wards, a nose swab was done. If the patient had previous MRSA history, a full screening would be conducted.
- The service had two incidences of methicillin sensitive staphylococcus aureus (MSSA) and two incidences of Clostridium difficile, from April to June 2016. The service had no incidences of MRSA from April to June 2016.

Environment and equipment

- The design, maintenance and use of facilities and premises generally kept patients safe. However, not all equipment had been checked as required and posed a risk that it may not have been safe for use.
- We reviewed five resuscitation trolleys on wards 1, 2, 7, 8, 15/16 and found that all of them were not consistently checked. On wards 1 and 2, we found cannulas that had gone out of date in August 2015. On ward 1, we also found a box which contained nine doses of adrenaline which had gone out of date in April 2016 and electrocardiogram (ECG) electrodes which were not stored inside their packaging so there was no way to tell when they went out of date. On wards 7, 8 and 15/16, we found the yankauer catheters were not in sterile packaging. Yankauer catheters are used to suction patients' mouths. We escalated this immediately to the ward sisters who took action to replace the items. We also noted that there was no resuscitation trolley or grab bag in the patient discharge unit and that the nearest resuscitation trolley was in cardiology. We raised this concern with the trust, who took immediate action to address this concern by emailing all staff to tell them that resuscitation trolleys need to be checked and signed daily and by introducing new audits of resuscitation trolleys. We were also told that these checks would be confirmed during the daily senior management safety huddles and that the data would be collated.
- We saw that the trust had audited the resuscitation trolleys in May 2015, October 2015 and June 2016. These showed that although compliance with resuscitation trolley equipment had increased, as a result of extra education, updating the trolley checklist and conducting spot checks, it was still below the required standard. It found that 55% of the trolleys audited had all items present, usable and in the correct quantities. This risk was not on the service's risk register.
- We found some chemicals, which could be hazardous to health, in unlocked rooms. On ward 3, we found an unlocked dirty utility room, which contained cleaning chemicals including liquid absorbing granules and high concentrated sodium chlorite. The chemicals were in a lockable cabinet however, the key had been kept in the lock. There could be risk of serious injury if patients or visitors were to ingest these chemicals. Also on ward 3, we found an unlocked storage room with needles in it. The storeroom had a keypad lock; however, the latch had been put on the door so that it did not lock. These were raised with the ward manager at the time of inspection who took immediate action to address the concern.
- On most of the wards we visited, there were tea trolleys in the corridors. These trolleys contained urns of boiling water, which could be a potential risk to patients with cognitive impairment. However, the service provided a risk assessment, which showed the steps taken to minimise the risks of scalding, including signage and heat resistant cups.
- During our previous inspection in October 2014 we found that patients in the waiting area of ward 1; the acute medical unit (AMU) were not visible to staff and had no way of calling for urgent help. During this inspection, we visited the AMU and found that although the waiting area was still not visible to staff, they had installed an emergency alarm which patients could use if they required help. We were also told that patients were not put in this room unless a relative accompanied them.

- The flooring in the wards was non-slip and was in good condition on all wards visited. There was clear access to fire doors and fire extinguishers were available
- Patient call facilities were in reach and wards had an electronic monitor at the nurses' station to show which patient had pressed their buzzer and the length of time they had been waiting.
- Window restrictors were used on the wards to reduce the risk of falls from windows and the blind cords were not a ligature or strangulation risk.
- The maintenance and use of equipment kept patients safe. We saw evidence that electrical equipment was safety tested and that they had been serviced. We also saw evidence that faulty equipment had been reported internally and there was clear signage to make it clear that the equipment was not to be used.
- The arrangements for managing waste and clinical specimens generally kept people safe. We saw sharp bins used in the sluices on the wards and appropriate bins for offensive waste.

Medicines

- The arrangements for managing medicines and medical gases generally kept people safe. Each medical ward had its own pharmacist, which meant that requests for medicines were dealt with quickly. We found that medicines were not always stored securely or safely.
- Medicines requiring refrigeration were kept in a locked fridge. Checks were completed daily to make sure that the fridge temperatures were correct, so that the medicines would not be compromised.
- On the AMU, there were separate locked cupboards for controlled medicines and patients' own controlled medicines, as the patients on the ward often brought controlled medicines with them.
- We reviewed 20 records, saw that allergies were listed as appropriate on drug charts, the charts were legible, and administration was recorded clearly.
- We found clinical pharmacists and technicians were involved in patients' individual medicine requirements which helped identify medicine issues and therefore they could be dealt with immediately. We observed a member of the pharmacy team checking a patient's medicine history to ensure the medicines prescribed whilst they were in hospital were correct.
- We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them.
- Staff knew how to report medicine incidents which were recorded onto a dedicated electronic recording system. Learning from incidents was cascaded to staff. We were told that on the ward there had been increased nurse training on how to record 'missed medication' to ensure that medicine records were accurate.
- If patients were allergic to any medicines then this was recorded on their prescription chart.
- Controlled Drugs were stored following safe and good guidance procedures.
- On AMU, the medicine storeroom was very warm. Daily temperature records documented that the temperatures were consistently at the highest temperature reading (25 degrees Celsius) for safe medicine storage. We were told that pharmacy were aware of this and were monitoring the temperatures.
- We found medicine storage was disorganised on wards 15 and 16 because the available medicine cupboards were too small for the amount of medicines stored. There was no locked door to the medicine storage area and we found open drawers containing fluids for injection. Due to the lack of space for medicine storage there were three 'overflow' locked medicine cupboards in the 'doctors' room'.
- On ward 15, we found an unlocked 'to take out' medicines (TTO) cupboard behind the nurses' station, which had medication for seizures inside. We raised this with a staff nurse who said that medicines were never normally kept in that cupboard and removed the medicine.
- Delays in waiting for medicines from pharmacy increased the time for discharge. It was recognised that the delays were mainly due to waiting for doctors to complete the prescription using the Electronic Discharge System.

Records

- Patients' individual care records were mainly written and managed in a way that kept patients safe. We reviewed 20 records and saw that almost all of these were accurate, completed, legible and up to date. We saw two record entries which did not make clear the author's position.

- We saw evidence of pressure area risk assessments, falls risk assessments, venous thromboembolism (VTE) risk assessments, handover accountability sheets, nutritional assessments, bed rail assessments, stool charts and 'we care around the clock' sheets in the patient records we reviewed. These were accurate, up to date and completed in accordance with the trust policy.
- On all the wards we visited, medical notes were held in keypad lockable cupboards. On almost all of the wards, the records cupboards were kept locked.
- Confidential records were mainly stored appropriately, however, on ward 3 we found a haematology request form which included the patient's name, patient number, date of birth, home address and GP details on top of a trolley,

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The staff we spoke to understood their responsibilities and adhered to safeguarding policies and procedures. Staff were able to give examples of safeguarding concerns that had arisen when patients had been admitted onto the ward with evidence of neglect or pre-existing pressure sores. They explained that they sought advice from the safeguarding lead if they were unsure whether a situation met the safeguarding threshold.
- On ward 2, the short stay unit, staff gave an example of a time they had raised a safeguarding alert for a carer of a patient, as they had concerns about how they were coping in the community.
- The safeguarding policy was in date and included guidance on prevention of radicalisation and domestic abuse. The trust had separate guidance and arrangements on how to act if staff came across a patient with suspected female genital mutilation.
- The service reported that 77% of staff had completed level one children's safeguarding training and 90% had completed level two children's safeguarding. In relation to adult safeguarding training, 64% had completed level one and 93% had completed level two. The service's target for completion of safeguarding training was 90%, so the service met their target for level two safeguarding children and adults.
- For level three safeguarding children training, 70 nurses had completed this.

Mandatory training

- Staff generally received effective mandatory training in safety systems, processes and practices. The service's target for mandatory training was that 90% of staff should have completed all aspects of the training. We saw that 86% of staff had completed their training in infection prevention and control, 86% of staff had completed medicines management training and 87% had completed their Mental Capacity Act training. In relation to moving and handling training, 87% of staff had completed their training. Furthermore, 87% of staff had completed the conflict resolution training. The service also reported that 82% of staff had completed basic life support training. This showed that whilst the service was not far off their mandatory training target, they were still below it, and therefore, there was a risk that staff were not kept up to date in changes in practice.
- The trust reported that 96% of nursing staff and 15% of health care assistants in the service had received essential skills training, which incorporated dementia awareness. The service's target for this training was 90%. The training was a new initiative, which was being phased in and was still being embedded at the time of the inspection.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. The service used the National Early Warning Score (NEWS) system for identifying and escalating deteriorating patients. We reviewed seven NEWS charts and found these were completed appropriately with evidence of escalation when required. We found one example where the NEWS chart had been completed but the total scores had not been calculated. This could lead to a risk of staff not escalating deteriorating patients, as they may not realise that the patient had deteriorated. However, in this instance the patient had not deteriorated and there was no harm as a result. The trust had a NEWS policy, which clearly outlined the criteria for escalating deteriorating patients.
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges. Staff told us that patients

with deteriorating health were put on a level one pathway. Patients on this pathway were then reviewed by the rapid response team and could be transferred to the high dependency unit or intensive care unit as appropriate.

- There were arrangements in place to ensure patients were reviewed daily by consultants once they were transferred from the emergency department onto medical wards.
- Each ward we visited also had a 'sepsis box' available. Sepsis is a form of blood poisoning. Sepsis boxes contain medication, including antibiotics, which are used to treat patients with sepsis. Staff said the box was rarely used as patients at risk of sepsis were identified early on by using NEWS and therefore intervention was given before sepsis onset. 'Think sepsis' posters were also displayed on the wards to remind staff about this. Additional sepsis training was available for staff.
- During our previous inspection in October 2014, we found that not all patients were assessed for risk of venous thromboembolism (VTE), not all patients aged over 75 years old were risk assessed for dementia and not all patients at risk of inadequate nutrition and hydration had completed food and fluid charts. During this inspection, we reviewed 20 records and saw evidence of VTE assessments, nutrition and hydration charts and dementia risk assessments being completed.
- Generally, falls risk assessments and care plans were completed according to trust policy. In one patient's notes on ward 3, we saw that a falls risk assessment had been completed, which indicated the need for a falls reduction care plan. However, the care plan template had not been filled out. We escalated this to a nurse who said it would be completed that day.
- On AMU they had access to floor lowering beds for patients at risk of falls. If these were not available then patients at risk of falls would be put on enhanced observations. On every ward we visited, we saw patients at risk of falls were wearing anti-slip socks in line with the trust policy.
- Staff also told us that they made psychiatric referrals if patients' mental health and wellbeing deteriorated. Staff on ward 8 and ward 2 explained that they sometimes called security for patients with behaviour that challenged. Whilst we were on ward 2, we saw a security officer enter the ward as a result of a disturbance. Staff dealt with this sensitively and appropriately.
- The trust had two respiratory wards: ward 15 which was acute respiratory, and ward 16 which was less acute respiratory. Ward 15 cared for patients requiring non-invasive ventilation (NIV) respiratory support. Ward 16 was planning to take patients requiring NIV from September 2016 and the ward was in the process of training its staff, including its three regular agency nurses, in NIV competencies.
- The service had an NIV policy, which stated that a medical specialist registrar had to review the patient and agree that NIV was necessary for the patient. The policy stated that patients with NIV could only be cared for on ward 15, the clinical decisions unit, the coronary care unit or the emergency department. The service's NIV policy was due for review in March 2015. The British Thoracic Society and Intensive Care Society released new guidelines on ventilatory management for patients in acute hypercapnic respiratory failure in March 2016. We saw that the service was aware that it was overdue and they told us that they were working to review it.
- The service had arrangements in place for patients requiring level two critical care. On ward 15: respiratory, one registered nurse was allocated to look after up to four level two patients in an acute four-bedded bay. On ward 17, cardiology, level two patients with a cardiac problem were admitted to the coronary care unit (CCU).

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment during the time of our inspection. Most of the wards we visited operated on a 4:3 ratio of nurses to health care assistants. Staff on the wards told us that staffing had improved since the last CQC inspection in October 2014 but that staffing was sometimes still 'a problem'. On most wards each nurse was responsible for one bay, which usually had six to eight patients. Staff measured patient acuity and flexed rotas to match patient dependency. The service used the Safer Nursing Care Tool Establishment, a recognised patient acuity tool, to determine levels of nursing staffing on the wards.
- Actual staffing levels were comparable to the planned levels for most of the wards we visited. Wards 7 and 15 were down one registered nurse on 12 July 2016. We saw that management had increased the number of health care assistants to offset the reduced number of nursing staff. In April 2016 actual staffing levels for general medicine wards varied between 93% and 95%

for registered nurses on days and between 100% and 102% registered nurses on nights. Staff also increased the number of health care assistants during the days when there were reduced nursing numbers.

- There were arrangements were in place to escalate concerns regarding staffing levels. Ward management attended a safety huddle every morning where they went through every ward and asked if staffing numbers were sufficient. The service had a staffing escalation policy and process in place whereby any unfilled shifts were escalated to a matron or the clinical site supervisor at nights. Management staff flexed permanent staff from ward to ward to cover vacancies.
- Arrangements for using bank, agency and locum staff were not robust despite a policy being in place. The service reported that they had filled 10% of registered nursing shifts with agency staff on average, in the three months prior to inspection. This was a reduction in the number of agency staff from the previous year, which had been 15%, as the trust had set up their own bank of nursing staff.
- We spoke to two agency nurses; one on ward 2 and one on ward 8. Both agency nurses told us that they had a brief orientation to the ward but had not had a formal induction and had not signed an induction book. We spoke to senior sisters on wards 1, 7 and 16 and they all confirmed that they were not aware of a formal process for induction of agency staff and did not record induction.
- We spoke to an agency nurse on ward 8 who told us that she had not had a formal induction to the ward. The agency nurse was providing one-to-one observation for a patient and said it was to stop the patient from leaving the ward. However, when asked, the agency nurse did not know if the patient was under a Deprivation of Liberty Safeguard (DoLS). This showed that the agency nurse was not given a thorough induction or handover for the patient she was caring for.
- Staff on ward 22 were aware of the trust's induction policy and we saw that agency staff inductions were being recorded. This meant that there was record that an induction had occurred for the agency staff varied across the service. Senior nurses told us that the service was not auditing the completion of agency induction checklists consistently. We raised this as a concern with the trust, who took immediate to address this concern by implementing an action plan of redistributing agency induction signing sheets, reminding all senior staff to ensure agency workers sign the form and planning to start auditing completion of the forms.
- The trust reported 13 incidents as a result of staffing pressures from April to June 2016. Whilst some of these did not have any adverse effect on patients, one partially contributed to a patient death whereby staffing pressures and use of agency staff led to delayed handovers and delays in actively treating the patient. It was reported that the agency nurses did not know how to do a crash call and did not know where the nearest resuscitation trolley was located. Following the incident, a notice was made informing staff of the nearest resuscitation trolley. Nurse staffing shortages was on the service's risk register, however, the risks of agency staff not being properly orientated to the ward was not on the risk register.
- The service had 107 full time equivalent nursing vacancies, which was 12% of their establishment. They reported that 80 Filipino nurses had recently been recruited to the service. We were told that that nursing retention was difficult, with staff on ward 7 informing us that they had recently lost several Italian nurses who had moved to London and Manchester. Staff told us that new staff would be joining wards 7, 8 and 16 in September 2016. The ward sister on ward 7 told us that she had asked for a band 6 position on every shift, which had been agreed, and that the recruitment for this had begun.
- Staff on respiratory ward 16 told us that if the acuity or needs of their patients increased then they booked extra staff and that management were supportive of this.
- Handovers occurred by the bedside and staff discussed the reason for admission, any progress since admission, any action plans and any relevant medical history. Staff told us that they received adequate information at handover.

Medical staffing

- The proportion of junior and senior staff was similar to the England average. The percentage of consultants was 35%, which was similar to the England average of 37%. The proportion of junior doctors was 21%, the same as the England average.
- All of the core training posts on the stroke unit were filled. This was positive as the positions were usually hard to recruit to.

Medical care (including older people's care)

- Consultants on the AMU completed ward rounds on the weekends and were then on-call out of hours. There was a consultant based in AMU during the weekends who was on-call to review patients in the other medical wards.
- Ward 17 had two long-term locums which formed part of their compliment of staff. Overall there were six consultant cardiologists at the service.
- The service had 21 full time equivalent medical vacancies, with departmental vacancy rates ranging from zero in neurology to 25% in respiratory.
- There were consultant led daily ward rounds in cardiology and stroke.. A separate consultant was on-call for new admissions and overnight. The on-call consultant also reviewed patients in other medical wards.
- The hospital operated a multi- speciality hospital at night team and the handover we observed was detailed and ensured all patients requiring medical review were identified and handed over to the incoming team. At this meeting, multidisciplinary teams worked together to ensure that patients received the correct care during the night when there were fewer staff. However, we were told that the surgical department often did not attend the handover for this and they did not attend the one we observed.
- Out of hours cover for the 297 medical beds was one registrar, two senior house officers and two junior house officers.
- The hospital had not yet implemented the recommendations for improved, standardised handover protocols as detailed in the Royal College of Physicians "Acute care toolkit 1: handover" dated May 2011 but were planning to do so.
- Staff told us that there was one consultant on call during the day over the weekend and would carry out a daily ward round for the patients newly admitted. There was no separate respiratory rota for the weekends. A cardiology consultant was on call over the weekends.
- Consultants carried out daily ward rounds during the week. Newly admitted patients were seen by the on call consultant at the weekends.
- As part of their induction, locum doctors were given an induction leaflet, which set out their duties, the facilities the service provided, advice on referrals, discharge summaries and handover information.

Major incident awareness and training

- The service used the trust wide incident response plan. This plan set out what staff should do in the case of a major incident and the chain of command in case of emergency.
- Ward sisters we spoke to were unable to tell us in detail what arrangements were in place to respond to emergencies and major incidents. They told us that there was a policy for such incidents and had a copy of this in their office but did not have working knowledge of this. They told us they would refer to the policy and escalate concerns to their line manager.
- Evacuation routes within the wards were free of clutter and kept clear.
- For the service, 85% of staff had completed their mandatory fire training, slightly below the target of 90%.

Are medical care services effective?

Good

Overall, we rated this service as good for effectiveness because:

- Patients generally had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- The Hospital Standardised Mortality ratio (HSMR) was significantly better the expected rate.
- Staff had regular one-to-ones and appraisals which was a significant improvement on the last inspection.
- Staff generally had a good understanding of the Mental Capacity Act and consent to care, treatment was obtained in line with legislation, and guidance and deprivation of liberty safeguards were applied appropriately.

However, we also found that:

- The non-invasive ventilation policy was out of date and had not been reviewed. New guidance relating to this had been released in March 2016, which meant there was a risk that staff were not following current guidelines. The service was aware that it was out of date and was planning to review this; however, there was no time scale for this.
- Performance in national stroke care audits had been poor but was improving.

Evidence-based care and treatment

Medical care (including older people's care)

- Patients generally had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. Relevant and current evidence-based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered.
- Trust policies based on National Institute for Health and Care Excellence (NICE) and royal college guidelines were available to staff and accessible on the trust's intranet.
- The service used the baseline assessment tool for NICE guidance on acute kidney injury in line with guidance CG169. The assessment tool found that the service was compliant with six out of seven applicable recommendations. The service could not show evidence of compliance with the recommendation on giving information about long-term treatment options as they did not audit this.
- The service also used the baseline assessment tool for NICE guidance on acute heart failure in line with guidance CG187. The service was compliant with six out of nine recommendations. The service was not compliant with two recommendations regarding performing echocardiograms as they had a long waiting list and needed to recruit four band 7 echo cardiographers. The service was also not compliant with ensuring that the patient's condition was stable for 48 hours prior to starting beta-blockers or discharging as this recommendation needed to be added to the trust policy. There was no lead recorded for ensuring this happened, nor a deadline for completion. However, the service had since incorporated this guidance into their policy on heart failure investigation and management.
- Assessments for patients were generally comprehensive and did cover all health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs. Patient's care and treatment was generally being planned and delivered in line with evidence-based guidelines. However, nursing care plans were not always person centred.
- We reviewed the trust's policy for the prescription and administration of oxygen in adults and saw that this was in line with National Patient Safety Agency alerts and British Thoracic Society guidelines.
- The trust's non-invasive ventilation policy for patients with respiratory failure was out of date by 16 months at the time of the inspection. New guidance relating to this had been released in March 2016. The service was aware that it was out of date and was planning to review this.
- Care pathways (multidisciplinary plans of anticipated care and timeframes) were in place for specific conditions such as neutropenic sepsis. We reviewed the trust's policy on this and saw that the policy was based on audit results, clinical research, the National Chemotherapy Advisory Group and National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) reviews.
- Assessments were carried out for the potential for skin damage and we found that all required assessments (included the national Waterlow score) and documentation was in place to provide staff with the appropriate guidance to manage patients' skin care needs effectively. Appropriate pressure relieving equipment was in place and we saw that wards had access to the tissue viability nurses.
- We also saw evidence that the service had implemented NICE guidance on Acute Kidney Injury: prevention, detection and management of acute kidney injury up to the point of needing renal replacement therapy (CG169) through their local policy.
- We saw evidence on ward 17 that medical staff followed European Society of Cardiology (ESC) guidelines and British Cardiovascular Interventions Society (BCIS) audits.
- Technology and equipment was used to enhance the delivery of effective care and treatment. We visited the physiotherapy gym on ward 7 where they had an exercise bike. This was programmed to have different resistance for each leg and would change the level of resistance to build up the patient's strength.
- We also saw that two wards (1 and 17) could see the most at risk patients' vital signs from the nurses' station, through use of an electronic system.
- The hospital followed the trust policy for management of sepsis (blood infection) and a sepsis bundle care pathway could be implemented if sepsis was suspected. The care pathway for suspected sepsis would usually be commenced in the emergency department. Wards had 'sepsis boxes' available so had access to appropriate antibiotics when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis.

- Staff told us they kept up to date with changes to NICE guidance through self-directed learning.

Pain relief

- Pain of individual patients were assessed and managed. We saw evidence in nursing records and NEWS charts of pain assessments being completed and pain relief being administered where required. On ward 3, we saw use of pictorial graphs, with happy and sad faces to help patients with limited communication indicate their pain scores.
- We spoke to six patients who said that their pain management had been maintained well. They said all their requests for pain relief had been considered and they had been given pain relief where appropriate.
- The service had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). The service had integrated these standards into their 'We care around the clock' programme, whereby staff asked patients every two hours if patients are feeling pain.

Nutrition and hydration

- Patients' nutrition and hydration needs were being assessed and met. We reviewed 20 patient records and saw that the malnutrition universal screening tool (MUST) had been completed for patients at risk of malnutrition. We saw some patients were nil by mouth and this was documented in their records and on signage behind their bed.
- Patients who needed assistance with eating were given red trays so that staff were aware they needed help. We also saw this was noted on their patient information board by their bedside and in the patient care plans. We saw that the trust's system of using red trays and red jugs, to indicate when patients were at risk of malnutrition or dehydration, were being used in ward areas.
- Dieticians provided support when requested. Staff completed nutrition assessments and they told us that dietetic support on the wards could be arranged if required.

Patient outcomes

- Information about the outcomes of patients' care and treatment was routinely collected and monitored. The information showed that the intended outcomes for people were generally being achieved.
- Outcomes for patients in this service compared well to other similar services. The trust ranked ninth lowest, which is ninth best in England, for the Hospital Standardised Mortality Ratio (HSMR) performance amongst 139 non-specialist acute trusts. The HSMR is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. For the 12-month period to February 2016, the HSMR was 81.The national expected HSMR score is 100. This means that the trust had a lower mortality ratio than expected, meaning that there were fewer deaths in the trust than expected.
- The trust also participated in the Summary Hospital-level Mortality Indicator (SHMI). The SHMI is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within 30 days of discharge is higher or lower than would be expected. The figure up to September 2015, which was the latest published available data, was 1.04. This put the trust as the 94th performing trust out of 142 non-specialist acute trusts, but was within the 'as expected range'.
- The trust participated in relevant local and national audits, benchmarking, accreditation, peer review, research and trials. The trust participated in the Sentinel Stroke National Audit Programme (SSNAP), the Lung Cancer Audit, the Heart Failure Audit, the National Diabetes Inpatient Audit (NaDIA) and the national Myocardial Ischaemia National Audit Project (MINAP) audit. The hospital did not provide a stroke thrombolysis service (this is a treatment where drugs are given rapidly to dissolve blood clots in the brain), as this was provided by another local NHS trust.
- The trust performed poorly in the SSNAP in July to September and October to December 2015, as well as January to March 2016. SSNAP is an audit that measures the quality of care that stroke patients receive throughout the whole care pathway up to six months post admission in England, Wales and Northern Ireland. The trust scored E overall for SSNAP level in all three audits, which is the lowest rating. The trust performed well in physiotherapy and discharge processes however, the score was reduced by the lack of occupational therapy, speech and language therapy and the length of time for patients to be admitted to the stroke unit. We saw an action plan was in place to attempt to improve this score, including the introduction of a 72-hour pathway document and an emergency bleep to get

stroke patients into the ward quicker. This was implemented in April 2016. The lack of occupational therapists was on the service's risk register; however, the lack of speech and language therapists was not. We saw that the service had advertised for occupational therapists to join the stroke unit, but this had been unsuccessful and they were in the process of re-advertising. The service was in the process of getting new agency speech and language therapists to increase their numbers. Senior staff said that there was a significant improvement on the most recent audit, which gave an overall Band C score for the SSNAP audit; however, this had not yet been published.

- The stroke ward; ward 7, had physiotherapists based on the unit seven days a week, and ensured that every patient on the ward had physiotherapy sessions every day. The length of time of physiotherapy varied depending on the patient's physical strength.
- The hospital performed well in the 2014 Lung Cancer Audit, which was published in 2015. The trust equalled or exceeded seven of the 12 targets, was significantly better than the national level in one target, and was about the same as the national level in the remaining three targets. This was an improvement from the 2013 audit.
- The trust performed well and above the England average in the 2014 Heart Failure Audit (published October 2015) for all indicators related to in-hospital care, including the input from a consultant cardiologist at 85%, better than the England average of 60% and 55% of patients were admitted to a cardiac unit or ward compared to an England average of 49%. Nine out of 11 indicators were better than the England average and only two, relating to referral to the heart failure liaison service, were worse than the England average. We requested a copy of the service's action plan to improve their performance in these two indicators; however, we were informed that one had not been devised.
- The trust had a mixed performance in the 2015 NaDIA. The trust performed better than other trusts for seven questions and worse than other trusts for nine questions. The service showed us their action plan to improve their performance in this audit. This showed that they had recruited more nurses to improve the number of specialist nursing hours, the launch of a diabetes community project to reduce clinic demand and podiatry support had been increased to five days per week. We also saw that the service had introduced a 'Think Glucose' staff education programme to meet the blood glucose testing requirements.
- The trust had a mixed performance in the MINAP audit of 2013/14, which reviewed the treatment, and care of patients who had suffered a heart attack. The trust performed better than the England average in two out of three indicators: for patients seen by a cardiologist and patients admitted to a cardiac ward. However, the trust performed worse in referring patients for angiography, which is an x-ray to examine blood vessels. Compared to the 2012/2013 audit the trust had improved in the percentage of patients seeing a cardiologist and referring patients for angiography, but worse than the previous year for patients being admitted to a cardiac ward. There was no data available for thrombolytic door to needle time for the hospital. We requested a copy of the trust's action plan to improve their performance in this audit. However, we were not provided with a copy of this.
- The risk of readmission for all elective (non-emergency) procedures at the trust was below the England average. The risk of readmission for non-elective general medicine and clinical haematology were also below the England average, however the risk of readmission for medical oncology, was slightly higher. This meant that generally patients, once discharged, were less likely to need to come back to the hospital for further treatment.
- Local audits were carried out by wards to assess compliance with completion of nationally recognised assessments such as the VTE and the Malnutrition Universal Screening Tool (MUST).

Competent staff

- Staff generally had the right qualifications, skills, knowledge and experience to do their job.
- The service had clear mechanisms in place to ensure appropriate levels of formal supervision of all staff. Staff at all levels said there was a structured approach for regular operational and clinical supervision.
- Learning needs of staff were identified during one-to-one meetings. We saw evidence of one-to-one meetings occurring, where staff discussed with their line manager any training needs. Training needs were also identified following an incident or complaint. We were

given an example of a medication error on AMU, following which the ward sister conducted refresher training for all staff, which counted towards their continuing professional development.

- Staff were encouraged and given opportunities to develop. We spoke to senior staff who told us that they had previously been acting up before taking on a management role full time. Medical staff told us that study hours were put into the work roster to ensure they had time to keep up to date with new developments and that they were given 10 working days off per year in order to attend academic conferences. Health care assistants were completing further training, such as the Health Care Certificate and National Vocational Qualifications (NVQ2).
- Generally, we found there were effective induction programmes for new permanent staff, not just focused on mandatory training, for all staff, including students. The learning needs of staff were identified during induction.
- The majority of staff said informal support from their managers was effective and provided when they needed it. Senior staff said they received excellent informal support from their line managers
- There were arrangements in place for supporting and managing staff via annual appraisals. During our previous inspection in October 2014, we found that not all staff received appropriate training and appraisals. During our inspection, we spoke to 18 staff who said that they had received a yearly appraisal and knew when their next appraisal was due. In the appraisal year from April 1 2015 to March 31 2016, 242 doctors completed an enhanced appraisal, with compliance at 97%. This was a 2% increase from 2014/2015 and an 11% increase from 2013/2014. Overall the appraisal rates in June 2016 for both doctors and nurses combined was 96% with only four staff not having had an appraisal. This exceeded the service's target of 90% of staff receiving an appraisal.
- Staff told us that they had received training in dementia awareness; however, none of the staff spoken to, including senior sisters, had received training in autism awareness and were unaware of any specific arrangements in place for these patients. The trust told us it provided learning disability training which covered autism and that they had a vulnerable adult's nurse who was available on site during the week to provide support to these patients.
- Two of the consultants on the stroke ward were also specialist stroke and geriatric consultants, which was useful due to the patient demographics on the ward.
- Half of the nurses on the stroke ward were general nurses and had not received specialised training in stroke care. The service had planned to run a training course with the University of Bedfordshire but this was not scheduled at the time of our inspection. We asked the service for evidence of plans to ensure that all nursing staff on the stroke ward had stroke competencies and were told that 12 nurses had completed a previous training course and that they were negotiating another for another six nurses. However, they were unable to provide us with any further information about their plans in the interim to ensure stroke competent nurses were on the ward.
- The trust was a designated body for medical revalidation and worked with 251 doctors to revalidate. This included consultants, specialty and associate specialist (SAS) doctors, trust grade doctors and NHS locums. All doctors have to revalidate their practice with the General Medical Council every five years, to ensure that their practice is up to date in the area of medicine that they practice. We requested data from the trust and saw evidence that doctors within medical wards had revalidated, while some doctors had had revalidation deferred by the trust's responsible officer.. One doctor had not engaged with revalidation in April 2016.
- Junior doctors said senior support was effective and that generally the quality of teaching was very good.
- Ward leadership staff were able to explain to us the process of poor performance management. There was an informal and formal process which was taken depending on the severity of the performance. We were also told that sickness management had been completed on staff in the past that had high sickness rates.

Multidisciplinary working

- A multi-disciplinary team (MDT) approach was evident across all wards. We observed effective MDT working in the wards we inspected. MDT meetings took place on the wards on a regular basis to review the progress of each patient towards discharge. MDT assessments on complex cases generally took place within 24 hours.
- Across all of the wards within inpatient services communication between the MDT team was integral to the patient's pathway.

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patients' care and treatment.
- The stroke ward had access to the early stroke rehabilitation team. This team was based in the community and provided care and support for up to six weeks following discharge from the trust. The team was made up of speech and language therapists, social workers, physiotherapists, occupational therapists, psychologists and rehabilitation assistants. The team attended board rounds and multidisciplinary meetings on the ward so that they knew who would need their service following discharge.
- The two respiratory wards (15 and 16) shared ward based speech and language therapists and occupational therapists.
- Access to psychiatric input was available through the mental health liaison team. The team worked to a 24-hour response time.
- We saw evidence of dietician assessments in patient records for those who required this and effective communication with ward teams.
- We spoke to an acute pain nurse on ward 8, who explained that they were part of the anaesthetic department but attended the ward three times per week to provide assistance to patients with liver disease or alcohol detoxing. Care was delivered in a coordinated way when different teams or services were involved.

Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were due to move between teams or services, including referral, discharge and transition. The medical wards had a proactive elderly care team (PECT) which included physiotherapists and occupational therapists. The team automatically received a list of all patients aged over 75 years old and came and assessed the patient's capacity, started discharge planning and made referrals for care in the community.

Seven-day services

- Senior staff said the service was looking at ways to fully adopt a seven-day a week working practice for doctors. Newly admitted patients were seen by the on call consultant at weekends as required, but there were not generally full ward rounds at the weekends.
- Some wards such as AMU, ward 17; cardiology, and ward 2; short stay unit, had consultant ward rounds at weekends but the other medical wards did not. There was an on-call consultant out of hours which was based on AMU and responded to requests for medical review across all medical wards. On call consultants reviewed all level one patients and all new admissions. Ward based discharge consultants worked both Saturdays and Sundays.
- For medical wards' cover at weekends, there were two registrars (one on-call and one ward based), and five junior doctors.
- There was an on-call overnight respiratory physiotherapist who attended to any urgent overnight physiotherapy needs for respiratory patients.
- The patient discharge unit was open from 8am to 8pm Monday to Friday and 9am to 3pm on Saturdays. The unit was closed on Sundays but had recently started opening on Bank Holidays.
- The trust had an on call pharmacy service to dispense medications out of hours and the pharmacy was open 9am to 3pm on Saturdays and Sundays. Staff on the medical wards also had access to the trust intranet, where staff could see which wards stocked medicines and requested a transfer if necessary.
- The medical wards reported that dietician services were available Monday to Friday and that on-call dieticians could be accessed if assistance was required for patients with nasogastric tube feeding, which is where patients are fed by a tube through their nose.
- There was a consultant on call 24 hours a day, seven days a week to respond to urgent cases of gastro-intestinal bleeds.
- Diagnostic services were available over the weekend and out of hours.

Access to information

- Information needed to deliver effective care and treatment was not always available to relevant staff in a timely and accessible way.
- The systems that manage information about patients generally supported staff to deliver effective care and treatment. All paper records were easy to access, with medical notes stored in locked cabinets which all staff members had key code access to, and nursing notes held by the patients' bedsides.

Medical care (including older people's care)

- When patients moved between teams and services, including at referral, discharge and transfer the information needed for their ongoing care was not always shared appropriately, in a timely way and in line with relevant protocols.
- Before the inspection we were made aware of an incident in March 2015 of a patient death following discharge as a result of a lack of correct information sharing. The service responded to this incident by updating policies and checklists to reduce the risk of reoccurrence.
- Doctors completed Electronic Discharge Summaries (EDS) to ensure appropriate information was available to healthcare professionals regarding patients' discharges.
- Generally, nursing staff said all the information needed to deliver effective care and treatment was available to in a timely and accessible way.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). We saw evidence that mental capacity assessments had been undertaken for patients who required this. All staff nurses were able to conduct mental capacity assessments. If staff were unsure then they asked the senior sisters for help. In the catheterisation laboratory consent was always taken by a consultant.
- The service reported that 91% of acute medicine staff and 92% of internal medicine staff had completed training on MCA and deprivation of liberty safeguards (DoLS). The service's target for training was 90%, so the service had met this. We reviewed the trust policy on MCA and DoLS and found that it had been due for review thirteen months earlier, in June 2015. However, there was no evidence that practice had changed since this time and as such the information in the policy was still valid and there was no impact on patient safety.
- Patients were supported to make decisions. We saw posters displayed providing contact details for Independent Mental Capacity Advocates (IMCA) for patients who lacked capacity and supported and represented the patients in the decision making process. We saw evidence in-patient records that patients were offered translation services if this helped them to make decisions about care and treatment.
- Patients' mental capacity to consent to care or treatment was assessed by nursing staff once the staff had reason to believe that the patient may lack capacity. Mental capacity assessments were undertaken on a trust template. This was a tick box checklist going through the stages of the assessment, and included details of next of kin. Consent to care and treatment was obtained in line with legislation, with deprivations of liberties applied appropriately. When patients lacked the mental capacity to make a decision, staff made 'best interests' decisions in accordance with legislation. We saw evidence of deprivation of liberties (DOLS) in place for patients who required this for their own safety. These measures included putting patients on one-to-one enhanced observations to ensure that they did not leave the ward.
- Staff told us that the senior sisters and the safeguarding lead would complete DOLS applications.
- The use of restraint of patients who lacked mental capacity was limited and action was taken to minimise its use. Ward 8; the gastroenterology ward, had patients who sometimes displayed challenging behaviour. We saw that chemical restraint, also known as sedation, was a last resort and was rarely used as other methods of de-escalating challenging behaviour were used instead.

Are medical care services caring?

Good

Overall, we rated this service as good for caring because:

- Patients received compassionate care, and patients were treated with dignity and respect. We saw that staff interactions with patients were person-centred and unhurried. Staff were focused on the needs of patients and improving services.
- Staff provided compassionate care to patients and interacted with them respectfully and considerately.
- Staff communicated clearly to patients and relatives and used private rooms for sensitive discussions.
- Patients and relatives we spoke with said they felt involved in their care and were complimentary and full of praise for the staff looking after them. Staff provided emotional support to patients and relatives.

- Allied health professionals worked well with patients to maximise their independence and confidence.
- The data from the friends and family test (FFT) was generally comparable with the England average. However, response rates were below the average.

Compassionate care

- Patients and those close to them were treated with respect, including when receiving personal care.
- Almost all patients felt supported and well cared for. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- The staff were kind and had a caring, compassionate attitude and had positive relationships with people using the service and those close to them. Staff spent time talking to people, or those close to them. Patients generally valued their relationships with staff and experienced effective interactions with them.
- Staff generally respected people's individual preferences, habits, culture, faith and background. Patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care.
- We observed staff taking the time to interact with people who used the service and those close to them in a respectful and considerate way. We saw nursing staff engaging well with patients, showing that bonds had been made between them.
- Staff showed an encouraging, sensitive and supportive attitude to people who used services and those close to them. We observed nursing staff engaging with patients and being sensitive to patients in distress.
- We also observed physiotherapists encouraging patients when providing walking assistance, phlebotomists being empathetic during blood sampling and domestic staff reassuring patients when cleaning spillages. We received good feedback from patients about the care received from staff, with one patient on AMU saying 'they are amazing…you can't fault it'. We were told by a patient on ward 2 that he had been 'treated with utmost respect' and patients told us that they could not fault the care they received.
- The response rates for the friends and family test scores (FFT) between 1 April 2015 and 31 March 2016 were slightly lower than the England average. The FFT asks patients whether they would recommend the hospital to friends and family if they had similar health issues. In May 2016, for the hospital's inpatients wards, the response rate was slightly lower than the England average of 26%, at 23%. The percentage of people recommending these inpatient wards was 97%, slightly better than the England average of 96%. Staff told us they were trialling giving the test before discharge to increase the number of responses.
- The FFT for ward 8 (general medicine and gastroenterology) had been consistently low since December 2015. This meant that patients on this ward had a more negative view on the care provided to them and would have been less likely to recommend it. We asked staff on ward 8 why their score was lower than other wards and they explained that as many of their patients go through alcohol withdrawal whilst on the ward they can find it very traumatic and therefore, have a worse view of the care they received.
- The service participated in the National Cancer Patient Experience Survey. The results from the 2015 survey; the most recent available, patients rated the care they received as eight and a half out of ten, on a score of zero being very poor and ten being very good. It found that 75% of patients felt they were involved in decisions about their care and treatment, 86% had a named clinical nurse specialist and 86% said they were always treated with dignity and respect.
- Generally staff made sure that patients' privacy and dignity was respected, including during physical or intimate care. We saw curtains were drawn around beds during intimate care or confidential discussions. However, we observed on ward 2 that on one occasion although the curtain was pulled around the end of the bed, the window blind was not drawn, so people in the corridor could see inside.
- Side rooms were offered for patients on end of life care if they were not needed for patients with infections. This meant that these patients and their relatives were offered greater privacy and dignity during this period.
- When patients experienced physical pain, discomfort or emotional distress staff did not always respond in a compassionate, timely and appropriate way. We were told by a patient on ward 8 that he had been concerned about a fellow patient during the night before our inspection. He explained that the other patient had not been changed during the night and that he had to raise this with ward staff. Another patient on ward 15 told us that the patient opposite him had to wait for over an hour for a commode to be brought to him.

- Staff respected confidentiality. We observed staff drawing curtains around beds for confidential discussions and most of the wards had a day room or visitor's room where confidential conversations could occur with more privacy if the patient was not bed bound.

Understanding and involvement of patients and those close to them

- Staff generally involved people who used the services as partners in their own care and in making decisions, with support where needed.
- Almost all patients who used the service felt involved in planning their care, making choices and informed decisions about their care and treatment.
- Staff mainly communicated with patients so that they understood their care, treatment and condition. We observed staff explaining to a relative about the possibility of the patient moving to another ward and explaining that they would be informed once a decision had been made.
- Wards had a named nurse system so patients and their relatives generally knew who was looking after them.
- We spoke to a patient on ward 2 who said that he had not understood the doctor who had explained what his scan was for. However, he told us that a nurse then came back and explained it to him again so that he was able to understand. We also observed nursing staff explaining medication when they gave it to patients, so that they knew why they were taking it. However, some patients we spoke to did not know who their named nurse was and said the staff changed over frequently.
- Staff recognised when patients who used services and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this.
- Staff ensured that patients who used services and those close to them were able to find further information or ask questions about their care and treatment. Ward 7 ran a relatives' clinic twice weekly so that relatives were kept informed and had the opportunity to ask questions. We also saw that information leaflets were available for patients and their relatives, as well as leaflets about charities which could help them following discharge.
- Patients who used services and those close to them were involved in planning and making decisions about their care and treatment. For patients living with dementia we saw staff used 'This is Me' booklets. This allowed patients living with dementia to still be involved with care planning and decision-making.

Emotional support

- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required.
- Staff understood the impact that a patient's care, treatment or condition had on their wellbeing and on those close to them. Mental health assessments were conducted by the mental health liaison team, provided by another local NHS trust, if there were concerns that patients had psychological needs.
- We saw staff providing emotional support whilst a patient was having a blood test, with a staff member sitting with the patient, holding her hand as she was distressed.
- Patients and relatives were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- Emotional support and information was provided to those close to patients who used services, including carers and dependants.
- Patients who used services were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. On most of the wards we visited we saw allied health professionals working with patients to maximise their independence and regain lost confidence. We saw staff encouraging patients to walk with mobility aids and supporting them to reach their goals.
- Patients were enabled to have contact with those close to them and linked with their social networks or communities. All the wards we went to had visiting hours when friends and relatives could visit.

Are medical care services responsive?

Good

Overall, we rated this service as good for responsiveness because:

Medical care (including older people's care)

- Whilst bed occupancy was very high, at 97%, above the threshold of 90%, patient flow was generally effective in the service.
- The service performed well for referral to treatment times; scoring 97% across the medical specialities.
- The trust had appropriate arrangements to transfer patients to other hospitals if they required treatment that the trust did not offer (such as thrombolysis and treatment for ST-elevation myocardial infarction).
- The service had a proactive elderly care team (PECT) who reviewed all patients over 75 years old and planned their discharge.
- Services met patients' needs, especially those living with dementia.
- Lessons from complaints and incidents were shared appropriately through use of staff newsletters and meetings.

However, we also found that:

- Not all patients were routinely being transferred or discharged from AMU within 72 hours of admission, though the service had reduced the number of patients with longer than planned stays from April to July 2016. The service did not have an action plan to improve their performance. We were advised that this had recently been added to the trust's transformation work streams.
- The service did not have a specific policy for dealing with outlying patients, and therefore, there was no formal procedure to follow in these instances.
- There were not any specific arrangements for caring for patients with autism.

Service planning and delivery to meet the needs of local people

- The service generally understood the different needs of the patients it served and acted on these to plan, design and deliver services. As well as the general medicine and speciality wards, the service had an ambulatory care service to cater for patients who required treatment but did not need to be admitted overnight. Patients on the unit received the same medical treatment as inpatients but this service reduced the amount of overnight stays. The cardiac team were in reach to AMU so they would be able to go quickly if they were needed on the ward.
- Planning of the delivery of the service was coordinated at daily safety huddles where ward leadership met to discuss staffing levels, potential discharges, outliers and bed moves.
- Commissioners, other providers and relevant stakeholders were involved in planning services. The service did not provide a hyper-acute stroke service as they did not carry out thrombolysis, which is where blood clots are dissolved by infusing an enzyme into the blood. Patients requiring this treatment were transferred to another local NHS trust. The trust also did not treat ST-elevation myocardial infarction (STEMI) patients (where the coronary artery is completely blocked) within the cardiology department but referred these patients to another local NHS trust.
- Medical services provided at the trust reflected the needs of the local population. Medical wards ring fenced beds, which meant they were protected from being used by medical outliers to ensure the individual specialities had sufficient bed space within the department. Medical outliers are where patients are receiving care on a different speciality ward.
- The facilities and premises were appropriate for the services that were planned and delivered. The patient discharge unit provided facilities for both bed bound and ambulatory patients. There were separate male and female seating areas, as well as two female and two male beds for patients who were unable to sit up. Patients with cognitive difficulties were not transferred to the discharge lounge but were discharged from the ward to reduce patient anxiety.

Access and flow

- Patients generally had timely access to initial assessment, diagnosis or urgent treatment. The service has performed very highly in the referral to treatment rates. The trust scored above 97% for all medical specialties, including 100% for rheumatology and thoracic medicine each month between April 2015 and March 2016.
- The two week cancer wait performance; the right to see a cancer specialist within two weeks of referral, for quarter four exceeded the target of 93%, being at 95%. This meant that patients were usually treated without delay.
- Whilst bed occupancy was very high, at 97%, above the threshold of 90%, patient flow was generally effective in the service. On the AMU, two members of staff told us

that patients who needed to be cared for in bed sometimes had to wait on trolleys in the ward corridors if there was not a bed immediately available for them on admission to the ward. For patients who were mobile, the AMU had a seated waiting area. We asked the trust for audit results to show how long patients waited to be given a bed on AMU. However, the trust did not audit this data so they were unable to provide this information.

- The trust had a generally mixed performance in terms of average length of stay compared to the England average. It had a lower average length of stay for gastroenterology, non-elective clinical haematology and medical oncology but a higher average length of stay for elective clinical haematology, respiratory medicine and general medicine. Length of stays were discussed every week by the senior nursing team. The service had an action plan in place to reduce length of stays, which included preparing to take home medications before 10am on the day of discharge. The service had a target of 42% for this and was currently achieving this in 41% of patients. The service had also implemented rotational operational liaison officers in February 2016 to support earlier discharges.
- Patients were generally transferred and discharged promptly. The service discharged 26% of patients before midday, and were working towards their target of 30%. The service also achieved 87% of the average weekday discharges at weekends, which was positive. Discharges occurred on Saturdays from the wards and the patient discharge unit, although the discharge unit was not open on Sundays. Any discharges on Sundays occurred directly from the ward.
- Patients were discharged from the service when relevant teams and services had been informed and when ongoing care was in place. The admission booklet on the wards had a discharge-planning checklist on the last page, which included a checklist for ensuring that any community-based care had been arranged. The service did not audit the completion of this checklist.
- There were 836 days of delayed transfers of care (DTOC) in June 2016, not including weekends as the trust did not keep data for weekends. This is where patients were medically fit for discharge but were unable to be discharged as follow on care packages had not been finalised. This equated to approximately 36 patients per day. We spoke to the ward manager on ward 3 who told us that five out of the 28 patients on the ward were medically fit for discharge but that they were waiting on care packages to be arranged by the local authority. The service had an action plan to reduce the number of DTOCs, which included giving patients details of expected discharge date on admission, increased liaison with GPs and working with the local authority.
- Discharge planning was inconsistent and did not always start on admission. We spoke to staff who confirmed that this was not always started on admission and saw discharge planning checklists within medical notes, which had not yet been started.
- Three copies of the discharge letter were printed, one of which was sent to the patient's GP to ensure they were kept up to date.
- During the previous inspection in October 2014, we found that patients were not being transferred from the acute medical unit (AMU) to an appropriate ward within 72 hours. During this inspection we found that this was still occurring. We saw that the service had a target of no more than 3% of patients remaining in the AMU for longer than 72 hours. Figures from April to July 2016 showed that the service was not meeting this, with 13% of patients remaining in April, 12% in May, 11% in June and 9% in July. However, these figures also showed that that the number of patients remaining in AMU was decreasing.
- The service did not have an action plan to improve their performance in transfer from the AMU to a medical ward. We were advised that this had recently been added to the trust's transformation work streams.
- We were informed by the senior sister that it was common for patients to stay in the AMU for one week and that one patient had remained on the ward for eight weeks. However, we reviewed an action plan, which was in place if this patient came onto the ward again to ensure that they did not stay that long again.
- Patients generally accessed care and treatment at a place and time that suited them. In June 2016, there were 117 medical outlying patients, which averaged to be four per day. Consultants from the required speciality reviewed these patients each day and they were moved to the appropriate ward as soon as a bed became available. However, the service did not have a specific policy for dealing with outlying patients, and therefore, there was no formal procedure to follow in these instances. We requested the criteria for outlying patients to other wards and evidence of risk assessing patients

who were outlying. The trust informed us that there was no set criteria or risk assessment completed before deciding to outlie a patient. We were informed that patients were selected by a nursing sister.

- Between 1 June 2016 and 30 June 2016, there were 202 bed moves at night, between 10pm and 7am, averaging seven patients being moved at night. The trust did not record the reason for the moves so we were unable to tell if this was due to clinical need or bed management.

Meeting people's individual needs

- Staff understood and respected patients' personal, cultural, social and religious needs, and took these into account and services were generally planned and delivered in a way that took account of the needs of different patients.
- Patients living with dementia had 'This is Me' booklets in their records, which included details of their cultural, social and religious needs if the patient was unable to communicate this directly to staff.
- The service had a proactive elderly care team who attended the wards daily to review any patients aged over 75 years old. The team assessed patients, provided multidisciplinary care and planned their discharges, which included arranging community-based care.
- Usually patients living with dementia were discharged directly from the ward, not from the patient discharge unit as this could unsettle them. There was no specific care of the elderly wards, so patients living with dementia were nursed with other patients. We were informed that 67% of nursing staff and 15% of healthcare assistants had completed Essential Skills Training, which included dementia awareness. The target for completion of this training was 90%. However, this was a new course which was being phased in at the service.
- Audits received from the service indicated that they screened 90% to 94% of patients aged over 75 for dementia in April, May and June 2016. All patients (100%) who were assessed as being at risk of dementia had a full diagnostic assessment and investigation. This was better than the NHS England target of 90%.
- We saw posters in the corridor of ward 3 which explained that the trust had a dementia lead nurse. Although ward 3 was not a dementia specific ward, almost all patients living with dementia were admitted there, unless they had a highly acute illness, which required specialist oversight. The ward manager of ward 3 had extensive experience in caring for patients living with dementia. On ward 3, extra health care assistants were used if they had patients requiring special requirements or needed one-to-one observations.
- We saw posters that promoted the dementia café, which provided emotional support to patients living with dementia and their carers.
- Adult admissions booklets were being used within the service. These templates contained areas to note information about the patient's social needs.
- Most wards had private rooms available for staff to hold sensitive conversations with patients and relatives.
- On the AMU, patients who were at higher risk of falls were put in beds nearer to the nurses' station, subject to space. This was so that they could be observed easier.
- There was a learning disability nurse who was aware of any patients who had a learning disability and was involved in their care. However, staff were unaware whether there were any specific arrangements for patients with autism. The trust did not hold specific autism awareness training. The trust held bespoke disability training in 2015, which included autism. Staff told us that they treated every patient individually and therefore, reasonable adjustments were made for patients with autism, as they would be for any other patient with complex needs.
- Reasonable adjustments were made so that disabled people could access and use services on an equal basis to others. Bathrooms and toilets were spacious to allow wheelchairs and walking aids into the rooms. We saw pictorial signs on the doors to bathrooms, so that patients with limited English fluency, reading problems or those living with dementia, were able to understand and access the bathrooms.
- Services engaged with patients who were in vulnerable circumstances and actions were taken to remove barriers when patients found it hard to access or use services. Staff had access to picture graphs to aid communication for patients with a learning disability. Pictorial pain charts were used in nursing notes to allow patients living with dementia or with limited communication, to indicate their pain score.
- The service monitored call bell response times that meant any deterioration of a patient was noticed quickly and staff could see which patients needed help.
- We spoke to six patients about food and menu choices. One patient told us that he did not always get enough food at dinnertime. Another patient told us that on one

occasion he had not received the food he had ordered. Both of these patients were on the respiratory wards. We saw that posters were up in the wards encouraging patients to ask for food if they felt hungry as it was available at all hours.

- Each ward had protected meal times to ensure that patients received adequate nutrition and hydration. Posters were on display to remind visitors of this.
- The discharge lounge provided sandwiches and drinks to patients awaiting transfers but did not generally have access to hot meals.
- The trust had a multi-faith chapel which provided spiritual and pastoral care. Within the chapel there was a dedicated Muslim prayer area with separate prayer space for men and women. There was also an on-call chaplain available at all hours.
- The service had access to translation services if English was not the patient's or relatives' first language. There were also posters displayed which provided information about Independent Mental Capacity Advocates (IMCAs), who represent patients lacking in mental capacity and help to ensure that they are still involved in the decision making process.
- We also saw that information leaflets were available on the wards for patients and their relatives, as well as leaflets about charities which could help them following discharge. Leaflets were also available in the patient discharge unit regarding after-care services that were available for patients.
- The trust had free Wi-Fi around the hospital site so patients could keep in touch with people through social media.

Learning from complaints and concerns

- Patients who used the service knew how to make a complaint or raise concerns. Information for patients and visitors about how to make a complaint was available on the trust's website and the wards had contact details for the patient advice and liaison service (PALS).
- Almost all patients spoken to knew how to make a complaint and would be supported to do this. Patients were treated compassionately and given the help and support they needed to make a complaint. The trust had a patient advice and liaison service (PALS) which provided support to patients or relatives if they had a complaint. Details of how to contact PALS were displayed on the wards.
- The service received 58 complaints from April 2016 to June 2016. The main themes of the complaints were communication failures (24), appointment delays or cancellations (21) and clinical treatment (15), which mainly focused on failures to treat, failures to follow up and inadequate pain management.
- Complaints were generally handled effectively. Minor complaints were sometimes dealt with informally at ward level and staff escalated serious complaints to the trust complaints' team. This was in line with the service's complaints policy. Formal complaints were reported electronically and were allocated for investigation as necessary.
- Staff told us that complainants received regular feedback on the ongoing investigation into their complaint. The divisional board meeting minutes from May 2016 stated that 27% of complaints were overdue a response, leading to concerns about the service's responsiveness to complaints. This compared to 11% of complaints, which were overdue in June 2016. The service had a target of responding to 90% of complaints within the specified time frame.
- There was an openness and transparency about how complaints and concerns were dealt with in the service. Staff spoke to anyone raising a complaint and kept a record of the conversation. Senior managers were also available to talk to anyone with a concern or complaint. Staff told us that senior sisters or matrons investigated complaints and provided feedback.
- Lessons were learned from concerns and complaints and action was taken as a result to improve the quality of care. Ward newsletters were produced which gave updates on recent complaints and themes and learning was shared through team meetings following complaint outcomes.
- As a result of a patient survey, ward 8 became aware that patients wanted to change the timing that they ordered their meals. The ward piloted a new meal service where patients chose their lunchtime meal in the morning and their evening meal at midday as opposed to ordering them the day before. This was well received and had since been rolled out across the trust.

Medical care (including older people's care)

Are medical care services well-led?

Good

Overall, we rated this service as good for well-led because:

- The trust had an overall statement of vision and values.
- Regular governance board meetings occurred which reviewed key areas of risk management and quality measurement.
- Risk registers were generally reviewed regularly and used to drive improvements.
- Local ward leadership was good and ward leaders were visible and respected.
- There was a positive culture across the medical wards with staff telling us they enjoyed working at the trust. Morale was high across teams.
- There was a culture of candour and honesty across the wards.
- Feedback was obtained from patients and relatives, which informed service improvements.

However, we also found that:

- Some staff on the wards were not fully aware of the trust wide vision and were unable to articulate what this was.
- Some junior staff on the ward at all levels did not demonstrate a full awareness of how risks were managed within the service and were not aware of risk management processes and systems.
- Whilst the risk register generally reflected the wards' safety and quality of care and treatment, we did find some risks were not recorded on the service's risk register.

Vision and strategy for this service

- The trust overall had a statement of vision and values, set out through the 'We Care' programme. The vision contained standards, including treating everyone with respect, providing timely care and attention, listening, informing and explaining, involving patients, being professional and maintaining a clean and comfortable environment.
- The trust strategy document stated that its strategy for achieving the 'We Care' vision was through education and training, research and development and service delivery. In April 2015 the trust became a university hospital, through partnership with the University of Buckingham in order to develop teaching and research. As a result of this there were student doctors and nurses on placement within the service.
- The vision, values and strategy were developed through consultation with staff and patients in 2013.
- However, staff we spoke to on the wards, of all levels, were not fully aware of the trust vision and were unable to articulate what this was. The service had plans in place to redesign the AMU service to reduce pressure on ward 1. There was also a five-year strategy plan for geriatric medicine to cope with the increase in aging population. Most staff on the wards were aware of these localised plans and visions for the future, and were able to explain what was going to happen and how this would improve the service.

Governance, risk management and quality measurement

- Staff we spoke to were clear about their roles and understood what they were accountable for. They had an awareness of the scope of their responsibility and said they would seek help from ward management if needed.
- Governance framework and management systems were regularly reviewed and improved. The medical division held monthly divisional board meetings. We reviewed the minutes of meetings held in March and May 2016. The areas covered during the meetings included finance, workforce planning, key performance indicators and risk registers and showed that the division was working to improve in these areas. We also saw that the medicine division held weekly team meetings. The minutes from 8 April 2016 and focused on plans for the then upcoming junior doctors' strike.
- There was a holistic understanding of performance, which integrated the views of people with safety, quality, activity and financial information. This was shown through the monthly divisional board meetings. The division discussed performance in relation to budgetary spend, numbers of incidents and complaints, clinical effectiveness and patient experiences. Staff were aware of the outcomes and actions from these meetings and were aware of the service's focus on these.
- There were comprehensive assurance systems and service performance measures, which were reported and monitored. We saw that there was referral to treatment targets for non-admitted patients waiting less

than 18 weeks, which the service was compliant with. There were also diagnostic targets of less than six weeks wait and cancer targets of two-week waits, both of which were flagged as red in the May 2016 divisional board meeting. This meant that the service was at risk of not being compliant with the targets. We reviewed the service's imaging improvement plan and saw that this was listed as an objective and the plan commenced. The lead consultant for cardiology had weekly meetings with the manager of the service regarding performance of the service.

- The service participated in systematic programmes of clinical and internal audits. However, the effectiveness of some of these local audits, such as the resuscitation trolley audits, were questioned when we found equipment and medicines which were out of date by over one year, but had not been identified by the audits. However, the trust took immediate action to address this once we had raised it as a concern and to strengthen the completion and robustness of the daily checks and audits.
- There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. The senior management team maintained the risk registers for the division. We saw evidence that new entries to the risk register were discussed at the monthly divisional board meetings and that risks had named staff owning the actions and that these were regularly reviewed.
- There was an alignment between the recorded risks and what staff told us they were concerned about. We looked at the division's risk register and saw that these were reviewed every two to six months, depending on the level of risk. We reviewed the trust's policy on risk management and saw that this was not compliant. The policy stated that moderate risks should be reviewed monthly and high risks should be reviewed every two weeks. We saw moderate risks on the register, which were due for review after six months and risks that had both an inherent risk level and current risk level of high/ significant, being scheduled to be reviewed after five months.
- We saw that low registered nurse staffing levels and available ward space, especially within cardiology, was on the risk register and was one of the main worries that staff told us about. Other risks listed included medical outliers and the effect they had on on-call staff over the weekend and lack of occupational therapists in the stroke ward; which was highlighted in the SSNAP audit, both of which staff were aware of and were working to improve.
- Not all relevant risks were listed on the service's risk register. We identified specific risks regarding the induction of agency nursing staff, which was not on the risk register at the time of the inspection. The lack of speech and language therapists in the stroke ward was also a risk, which was not recorded in the register.
- We asked staff about ward specific risk registers but they were unaware of whether these existed. Staff on the ward at all levels did not demonstrate a full awareness of how risks were managed within the service and were not aware of risk management processes and systems. They would however, escalate their concerns to their immediate line managers or through the electronic reporting system.
- Cardiology held monthly multidisciplinary team governance meetings. We reviewed the minutes of the April 2016 meeting. The meeting covered mortality and morbidity, flow, space, clinical pathways, staffing updates, governance reports and educational planning and evidence of learning and actions arising was evident.

Leadership of service

- Leaders within the service, of all levels, were visible and approachable. Staff told us that the senior leadership team, including both senior management and lead clinicians and nurses, were visible and effective. Local ward leaders were known within teams and appeared to communicate well with staff. We saw effective team working and evidence of positive working relationships between staff and the ward leadership.
- Leaders encouraged appreciative, supportive relationships among staff. We were told by staff that leaders were supportive and approachable and that they promoted good working practices.
- Staff and leaders in the wards prioritised safe, high quality, compassionate care and promoted equality and diversity.
- The ward leaders understood the challenges to good quality care and identified the actions needed address them. The most common challenge mentioned was staffing, and ward leaders explained the current recruitment process to try to alleviate this.

- Ward nursing staff told us that they felt supported by their line managers. We spoke to a newly qualified nurse who said she felt well supported within the new role.
- We were told that the clinical lead for cardiology had improved engagement with colleagues and the service over the past year.
- The matrons attended the wards once a week to talk to staff, patients and relatives and receive any feedback.

Culture within the service

- Staff we spoke to felt respected and valued. Many of the staff we spoke to had worked within the division for at least a year and felt that it was a good place to work. Staff who had worked for the trust for longer told us that they had seen an improvement since the last CQC inspection, and that the trust was now a better place to work.
- Staff did not express concerns about bullying or harassment. The service had not received any bullying or harassment concerns from staff from March to June 2016.
- Across the service there was a good positive culture and there were good working relationships between medical and nursing staff. Nursing staff felt confident in challenging medical staff if necessary and their challenges were well received.
- The culture was centred on the needs and experiences of patients who used services. Across the service staff consistently told us of their commitment to provide safe and caring services and spoke positively about the care they delivered.
- The culture on the wards encouraged candour, openness and honesty. We spoke to several ward sisters who promoted this and showed an awareness of their limitations and a willingness and enthusiasm to improve upon these areas. In the catheterisation laboratory, the duty of candour was well implemented and all risks of procedures were fully explained before starting the procedure to ensure that patients are well informed.
- There was an emphasis on promoting the safety and wellbeing of staff within the service. Staff we spoke to said that the working environment and culture had improved since the last CQC inspection, as a result of an increase in staffing. On ward 8, security were called if there were patients with challenging behaviour that could result in physical danger to staff, the patient or other patients.
- Whilst we were on inspection nominations were open for the annual staff awards.
- Staff and teams worked collaboratively, resolved conflict quickly and constructively and shared responsibility to deliver good quality care. We saw good collaborative working between doctors and nursing staff on ward 2 when a patient became very distressed and agitated. They effectively de-escalated the patient and ensured they received both the physical care and emotional support he required.
- Staff were confident in using the trust's whistleblowing procedure if required.
- Staff sickness levels were relatively stable from May to July 2016. Sickness levels for the service were around 5% for all three months.

Public engagement

- Patients' views and experiences were gathered and acted on to shape and improve the services and culture. The trust participated in the patient experience survey. The matron attended the medical wards once per week to talk to patients and relatives and receive feedback.

Staff engagement

- Staff felt engaged and that their views were considered in the planning and delivery of services and in shaping the culture. Leadership were approachable and staff felt confident in raising concerns or sharing suggestions with their seniors. Staff felt that their comments were well received and that they were considered by the leadership.
- Both leaders and staff understood the value of staff raising concerns. There was an open culture on the wards and leaders advocated staff reporting incidents.
- Leaders were aware that front line staff would have more exposure to patients and would be more likely to pick up on concerns and so encouraged staff to report these so that ward leadership would be aware.

Innovation, improvement and sustainability

- Staff were focused on continually improving the quality of care and the patient experience. Staff at the trust undertook an improvement project regarding the ward environment, specifically focusing on reducing the level of noise. The project found that by implementing noise reducing measures ward levels reduced by approximately 15 decibels which helped to improve the patient experience and allow staff to concentrate better.

Medical care (including older people's care)

- Improvements to quality and innovation were recognised and rewarded through the annual staff awards. Within the awards scheme there were categories for most improved clinical area, excellence in patient safety and excellence in patient experience.

Maternity and gynaecology

Safe	Good
Well-led	Good
Overall	Good

Information about the service

The trust's maternity service at Milton Keynes Hospital provides antenatal, intrapartum and postnatal care to patients. The service also includes a delivery theatre in the main theatre suite and provides community based midwifery services. There were 3,937 deliveries between June 2015 and May 2016.

There are 11 beds on the labour ward, 13 beds on ward 10, the postnatal ward, and 28 beds on ward 9, which is a mixed post and antenatal ward. There are cots available for each bed. There is a day assessment unit, which has capacity to care for four patients. This was not open at night. There was an early pregnancy assessment unit, which was not open at night.

There were designated gynaecology beds on the surgical assessment unit (SAU) beside the early pregnancy assessment Unit (EPAU); these patients were admitted to the surgical assessment unit that had 24 beds for mixed surgical specialities.

On 12 and 13 July 2016, we carried out a focused inspection of the service. We inspected the service in the key questions of safe and well led. We did not inspect, or therefore rate, the service for effectiveness, caring and responsiveness. During our inspection, we visited the labour ward, wards 9 and 10, the antenatal clinics, the early pregnancy assessment unit, operating theatres and the surgical assessment unit.

We spoke with 12 patients or their relatives and 17 members of staff within the service. We observed care and treatment and looked at eight sets of care and medical records. We received comments from people who told us about their experiences and we reviewed performance information about the trust's maternity service.

Summary of findings

On the last inspection, all five key questions were rated as good. At this inspection, we rated safety and well-led as good. We found that:

- The trust had established an improvement board to review incidents and risks and to drive improvements in the service. Information was used to develop the service and continually improve. The service was focused on continuous improvement.
- There was a lower rate than the national average of neonatal deaths. The maternity improvement board was monitoring this to make further improvements in the service.
- Changes in practice and training had been put in place following lessons learned from incidents. Improvements had been made in response to serious incidents.
- There was sufficient equipment on the wards to keep women and babies safe including new areas for resuscitating babies, blood pressure monitoring devices and a centralised cardiotocography (CTG) system. Systems were in place to make sure that women were monitored and looked after closely.
- Staff were adequately trained, encouraged, and supported to continue with their professional development. Midwifery, gynaecology nurse, and medical staffing met patients' needs at the time of inspection.
- At times of peak demand, the service escalated the overall safety status of the maternity unit as necessary. Appropriate escalation plans were in place.
- There was a clear vision for the service and staff understood the trust's values.
- Leadership was well defined and visible. Leaders had been appointed in all the maternity and gynaecology sub specialities with clear work plans and objectives.

Maternity and gynaecology

- Midwives and gynaecology nurses' roles had been developed to support the service and provide a greater level of expertise for patients.
- Governance, risk management and quality measurement systems were in place and used to monitor and improve safety, treatment and outcomes for patients.
- The culture within the nursing and midwifery teams was caring, supportive and friendly. All nursing and midwifery staff we spoke to told us that they were happy at work.
- Whilst there was not always adequate space for storage of equipment not in use, the service had noted this as a risk and had raised awareness amongst staff teams to constantly assess the situation for risks to patients.

However we also found that:

- Some gaps in emergency trolley documented checks were found and the service actioned this immediately when we raised it as a concern.
- There was poor monitoring of the risk of venous thromboembolism (VTE) and the service had actions plans to place to address this concern.
- Women could be separated from their babies after a caesarean section due to limited recovery space in the operating theatres.
- There were at time gaps in the implementation and recording of information about intentional rounding carried out on labour ward. The service was monitoring the completion of these records.
- External, regional health service planning had affected the service's development plans.
- In the maternity service, some examples were shared with inspectors of poor communication, inappropriate behaviours and lack of teamwork at consultant level within the service. From discussion with senior managers, it was clear that some issues had been recognised and active steps were being taken to optimise communication and team working. Such behaviours were not observed during the inspection.
- The service website information was very limited.

Are maternity and gynaecology services safe?

Good

Overall, we rated the service as good for safety because:

- There was a lower rate than the national average of neonatal deaths. The maternity improvement board was monitoring this to make further improvements in the service.
- Changes in practice and training had been put in place following lessons learned from incidents. Improvements had been made in response to serious incidents.
- There was sufficient equipment on the wards to keep women and babies safe including new areas for resuscitating babies, blood pressure monitoring devices and a centralised cardiotocography (CTG) system. Systems were in place to make sure that women were monitored and looked after closely.
- Staff were adequately trained, encouraged, and supported to continue with their professional development. Midwifery, gynaecology nurse, and medical staffing met patients' needs at the time of inspection.
- At times of peak demand, the service escalated the overall safety status of the maternity unit as necessary. Appropriate escalation plans were in place.
- Whilst there was not always adequate space for storage of equipment not in use, the service had noted this as a risk and had raised awareness amongst staff teams to constantly assess the situation for risks to patients.

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Maternity and gynaecology

Incidents

- All staff understood how to raise concerns and record safety incidents including concerns and near misses. When things did go wrong, thorough and robust reviews were carried out. The service was focused on learning lessons to make sure action was taken to improve safety.
- From July 2015 until July 2016, there were 1,197 reported incidents. Four were of major severity, two of moderate severity, 770 of minor severity. 420 incidents were unclassified.
- Eight of the incidents were categorised as serious incidents. They were either reported on or were being reported on in line with trust guidelines about the reporting of serious incidents and root cause analyses were being carrying out.
- There had been no never events reported by the service in the past year. A never event is described as a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- In the period up to December 2015, the coroner opened inquests into five deaths of babies that had been born at the trust. Four of the five had been transferred to other neonatal units and subsequently died there. The maternity service had responded to the outcomes of the coroner's inquests and areas for improvements had been reviewed at the service's improvement board, which had been set up in response to these cases. The improvement board met every two months and had participation from all relevant stakeholders and commissioners. We saw extensive improvement plans in place that were being monitored to drive improvements throughout the maternity service.
- Incidents that were more serious were referred to an identified senior person within the service, with training in investigating incidents using trust guidelines for the investigation, and a root cause analysis was produced. The reports were used to identify lessons to be learnt and if required, changes to practice. There was a consultant responsible for governance and incident investigations.
- Following serious incidents investigations, reports and root cause analysis were carried out and recommendations were made to reduce the risk of a similar incident happening again. The recommendations were communicated to all necessary staff and changes in practice implemented and monitored.
- There were goals, action plans and regular reviews of the service improvement plans. For example, there had been a risk to patient safety identified regarding the use of Cadiotocography (CTG). This is a way of monitoring a babies' heart activity in the womb. Due to this, a training schedule had been implemented and ongoing training was planned, with the aim of decreasing the number of incidents that may have arisen due to poor interpretation of CTG monitoring.
- There was a specialist risk midwife in post. After an incident, the risk midwife would make an initial assessment and decide which member of staff would lead an investigation. For low risk incidents, this was a local senior midwife or manager. The risk midwife had responsibility for monitoring incidents via the reporting system, reporting on, analysing and sharing lessons learned through incidents.
- Staff told us that when there were lessons to be learned, emails were sent out, a message of the week was provided at handover to all staff, there was a notice board in the labour ward and, if necessary, individuals were emailed at home to provide support in learning from mistakes.
- There was a specific maternity risk management newsletter called "Closing the Loop" which was published and circulated to staff regularly to communicate recent and relevant safety issues and learning points for all staff.
- The trust held monthly morbidity and mortality meetings. These were both at trust level and at departmental level. The departmental meetings reported to the trust mortality review group, the trust mortality board and then the trust quality board. Morbidity and mortality meetings were well attended by doctors and senior nurses. Recent cases of unwell patients were presented and discussed. Ways in which practice could be developed to improve diagnosis times and procedures were discussed and actions put in place to make positive changes.
- Senior members of staff told us they wanted to see an increase in reporting of incidents as a method of learning. This was so that trends in incidents could be identified and lessons learned could be shared. A minority of staff told us that when they reported

incidents they did not always get a helpful response. For example, the response to one the incident was recorded as “staff pressures” when the concern related to a doctor not being contactable when on call.

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- We saw that the duty of candour process had been followed. This means that when a mistake was made that the department were honest and open with the person involved about the incident and either actual or potential consequences, invited them to continue to receive information about the investigation and issued a letter of apology as soon as possible after the event. Staff told us of patients that had been affected by something that went wrong. Staff told us that the patients were told of the incident, given an apology and informed of any resulting actions.
- We saw the Mothers and Babies, Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK) perinatal mortality report (2016) which reported on deaths for the calendar year 2014. This report was published in May 2016 and was a comprehensive report covering the whole of the United Kingdom which collated stillbirth, perinatal and extended perinatal deaths data from 39 participating NHS trusts. This report showed that the service had perinatal mortality rates for the calendar year of 2014 that were up to 10% better than the national average.
- Adjusted still birth rates for the service were 3.46 compared to an average of 3.56, better than the average for the participating trusts. The service performed 4th best out of the 39 participating trusts for this score. Adjusted neonatal mortality rates for the service were 1.37 compared to an average of 1.33 which was marginally worse than the average for the participating trusts. The trust performed 28th best out of the 39 participating trusts for this mortality measure. Adjusted perinatal mortality rates for the service were 4.69 which were better than the average of 4.88. The service performed 11th best out of the 39 participating trusts for this mortality measure.
- The service had plans in place to hold joint working governance meetings with another local acute trust to share processes and lessons learned. The MBRRACE findings were being closely monitored by the service and all relevant stakeholders via the maternity service improvement board. The minutes of this board’s meeting in June 2016 reflected the findings of the report and what plans the service had in place to further improve performance.

Safety thermometer

- An appropriate range of safety information was being monitored by the service. The service collected information about safety risks to patients. This information included the total number of hospital acquired pressure ulcers, the number of hospital acquired infections, the number of medication administration errors, friends and family test response rates and the percentage of respondents who would recommend the service, maternity documentation standards and maternity staffing levels.
- Specifically to obstetrics, the information collected included the number of inductions of labour, the number of caesarean sections, any complications of labour and delivery. This included the number of stillbirths, breech births and shoulder dystocia. This is when a baby’s shoulder is stuck on delivery and can cause damage to the shoulder and arm. Perineal and/or abdominal trauma, post-partum haemorrhage and Apgar scores of less than seven at five minutes after birth. Apgar scores are used to assess the condition of a baby at one, five and 10 minutes after birth. They have a range of zero to nine with zero being a poor score. It also included the percentage of normal, home and instrumental deliveries. Gathering this information and looking for patterns in comparison with national averages helped the service to identify areas for improvement.
- There was a large increase in women commencing breast-feeding from 58% in the previous year to 77% in the first three months of the year April 2016 to March 2017. However, we saw a decrease in women continuing to breast feed at discharge home for ongoing

community midwifery care. This fell from 46% in the previous year to 43% in the first three months of the year April 2016 to March 2017. The community midwifery team was being developed to provide more midwives to support women at home.

- We saw that there was a marginal decrease in women smoking in pregnancy compared to the previous year.
- In May 2016, we saw that there had been no hospital acquired pressure ulcers or hospital acquired infections. This was the same as the year to date figures.
- The number of women assessed for risk of venous thromboembolism (VTE) was 74% by obstetricians and 60% by midwives. This is against a departmental target of 95%. The service had reminders in safety updates for staff to assess all women for VTE risk and that the recording of this was being audited internally. Actions plans were in place to address this risk and senior managers were monitoring audits outcomes to improve compliance with this performance measure.
- There were six stillbirths for the months of April, May and June in 2016 the number for the whole of the previous year was 13. This was double what would be expected for a unit of this size. The service had a process in place for reviewing all deaths including stillbirths through the trust's mortality and morbidity processes and, where appropriate, the trust's serious incident review group .
- We saw that the target of post-partum haemorrhage was four for the three months from April to June 2016, but that there had been a total of nine. The department were monitoring the incidents and looking for common themes to see if there was a way of reducing this or it was a coincidence.
- In the year to date, 44 babies had been admitted to the neonatal unit. The planned numbers for admission to the neonatal unit for babies older than 36 weeks gestation was 36. The service was looking for common themes for the higher than expected rate of admissions.

Cleanliness, infection control and hygiene

- Wards and clinical areas we visited were visibly clean. Generally, the service had appropriate systems in place to minimise the risk of patients acquiring an infection whilst in hospital.
- Patients told us that they were very happy with the cleanliness of the maternity unit.
- Staff were observed to clean their hands before and after patient contact in accordance with trust policy.
- Hand hygiene audits were completed regularly and ward 9 was found to be 100% compliant with hand hygiene in March to May 2016. However, the auditor noted that a low number of hand hygiene actions had been observed. The ward had only returned 12 audit forms in March and April 2016 and 17 in May 2016 rather than the required 40. There was a risk that a small number of observations may not provide a true picture of the actual practice of hand hygiene.
- There were "I am clean labels" on equipment on the surgical assessment unit (SAU). There was a cleaning schedule and policy on display on the SAU. We saw evidence of cleaning schedules and policies on the SAU.
- In the maternity service, staff said after a piece of equipment had been used the nurse responsible for its use would clean it. This was not documented nor were "I am clean" stickers used. Equipment appeared visibly clean during the inspection.
- The storage and dispensing of gloves and aprons was not always adequate. Some aprons were balanced on top of glove storage units. This meant that they would regularly fall to the floor before being used. This was reported to a senior manager at the time of inspection, who told us she was not aware of this method of storage and would take action to provide appropriate storage facilities.
- All hand sanitiser dispensers in all clinical areas were found to be stocked. However, the positioning of some of the dispensers did not allow staff the best access to them at all times. For example, hand sanitiser was not available outside the doors of any of the labour rooms. It was available inside the rooms. Hand sanitiser in pump dispensers were seen to be hanging off the trolley guardrails around one of the wards.
- The majority of staff were seen to be adhering to "bare below the elbow" policy. Two doctors were observed to be wearing items of clothing or jewellery below the elbow. This could be a way of carrying infection to patients. One doctor was challenged on a ward and responded that they were "just collecting notes not seeing a patient". This was observed by a senior nurse who noted the exchange and agreed to discuss this with the doctor concerned
- The trust had policies for screening and treatment of c-difficile and MRSA infections. From March 2016 to May 2016 there were no reported infections of either MRSA or C-difficile within the service

Maternity and gynaecology

- In the year April 2015 to March 2016, the trust told us that there were 112 instances of puerperal sepsis and other infections in the 42 days following birth. These included: infection of obstetric surgical wound, other infection of genital tract following delivery, urinary tract infection following delivery, other genitourinary tract infections following delivery, pyrexia of unknown origin following delivery and other specified puerperal infections.
- Medical staff had had training in sepsis management, infection control and prescribing antibiotics during their induction to the trust.
- The service had an annual infection prevention and control team programme of work for 2016/17. This showed that the service had a plan for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of monitoring systems'.

Environment and equipment

- Generally, the design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment generally kept people safe with the exception of some gaps in emergency trolley documented checks. The service actioned this immediately when we raised it as a concern.
- Whilst there were some space limitations due to the current premises used by the service, senior managers had plans to reconfigure the service, but these were dependent on the ongoing discussions about how maternity services were to be provided in the region, across different hospital sites.
- Entrances in all the areas where babies were cared for were entered via secure, locked doors with intercom communication. The doors could only be opened by internal mechanism or by a swipe card system on the outside.
- The clinical areas and wards in the maternity and gynaecology service were separate. This meant that if an emergency happened in the antenatal assessment unit (ADAU), the labour, antenatal or post-natal wards and a doctor was some distance away on the surgical assessment unit (SAU), they might take some time to reach the patient at risk. The service was aware of this risk and had categorised it as a low/insignificant risk. There was no evidence of any impact on patient care due to this environmental issue. There were plans to move the Early Pregnancy Assessment Unit (EPAU) and the gynaecology patients to a ward nearer to the rest of the maternity services. However, these plans had been halted due to the ongoing discussions about regional service development.
- There was no dedicated theatre in the maternity unit for obstetrics. There was a theatre in the main theatres used for obstetrics (theatre three). The journey to the theatre from the labour ward was over a corridor and via five set of doors. There was no evidence of any impact on patient care due to this environmental issue.
- Women who had had medical terminations of pregnancy were cared for in the same recovery area in the operating department as women who had caesarean sections, as there was no dedicated recovery area for women who had had a caesarean section. This meant that at times women may have been separated from their baby after they have given birth. This was to protect women who have had surgical terminations from the distress of hearing and seeing a new-born baby. However, the National Institute for Health and Care Excellence (NICE) guidelines for successful breast feeding state 'separation of a woman and her baby within the first hour of the birth for routine postnatal procedures, for example weighing, measuring and bathing, should be avoided unless these measurements are requested by the woman, or are necessary for the immediate care of the baby'. [2006].
- The trust was working towards level two of the UNICEF Baby Friendly Awards, having achieved level one. This practice of separating women from their babies did not fit the requirement of the level two award so the service was planning how the design and layout of the premises might be adapted in line with the long-term discussion about service development in the region.
- Equipment in the department was electrically tested to be fit for use.
- Emergency trolleys such as neonatal and postpartum haemorrhage trolleys were not checked daily. On the postpartum trolley, as of 12 July 2016, two days had been missed. In June 2016, four out of 30 days had been missed and five out of 30 days were unaccounted for. On the intravenous access trolley in June three days had been missed and until 12 July, one day had been missed. On the instrumental trolley three days were missed in June and one day in July. On the neonatal resuscitation trolley, three days were missed in June.

Regular audits of emergency trolleys had been undertaken. We raised these missing documented checks as a concern during the inspection and the service took immediate action to address the issue.

- There was not always adequate space for storage of equipment not in use. This could pose a potential risk to staff and patients when trying to get to an emergency. The service had noted this as a risk and had raised awareness amongst staff teams to constantly assess the situation for risks to patients. Cardiotocography (CTG) machines were stored in the same room as the birthing pools as there was no other suitable storage for them.
- Not all delivery rooms had an ensuite bathroom. This meant that a woman in active or late stage labour would need to go to a shared bathroom, which could compromise her privacy and dignity. This did not occur during our inspection.

Medicines

- Generally, there were effective systems in place regarding the handling of medicines.
- We saw that medicines were generally stored securely. The service's drugs and medicines were stored behind doors with key code locks. We found a storeroom on ward 9 to be unlocked with intravenous fluids easily accessible as well as intravenous fluids containing potassium chloride. This was raised immediately with the ward manager who showed us that the door had not been clicked shut and took immediate action to address this risk.
- Fridge temperatures where medicines and babies milk was stored were checked and recorded daily. This meant that if the temperature was higher or lower than the items required that action could be taken to discard any spoilt medicine or milk.
- Records seen showed that ordering, receiving, recording, and dispensing medicines were accurate and up to date.
- We looked at eight sets of prescription records. All prescription charts and drugs records were completed accurately.
- On SAU, we saw a form for recording the giving of blood to a patient. There was no space for the person completing the form to sign that they had carried out observations. This was raised with the sister in charge who told us she would bring it to the attention of the unit managers.
- Arrangements were in place for safe disposal of waste and clinical specimens.
- We saw that in the month of May 2016 (and in the current year) there had been one medication error and that this had been investigated.

Records

- Patients' individual care records were written and managed in a way that kept people safe. Records seen were accurate, complete, legible, and up to date and were maintained in accordance with trust policy. We reviewed eight sets of nursing records and four sets of medical records.
- In all the areas we visited, we saw that medical records were securely kept in locked trolleys with key code access points. Nursing records were kept at the side or end of the patients' beds in ward areas.
- All pre-operative checklists were competed accurately and signed and dated in accordance with trust policy.
- There were regular audits of record keeping which showed the following: observations had been completed in 95% of records against a trust target of 95% in May 2016. Triggers (an increase in risk to patients) had been documented in 100% of records. Evidence of escalation was documented in an average of 89% of records in the year to date against a trust target of 90%. Overall there was a total of 88% of documents accurately completed against an overall target of 91%. Senior managers were monitoring the completion of all required records on a regular basis and reporting audit findings to the maternity improvement board.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- There were comprehensive safeguarding policies for adults and children. The policies contained information about child sexual exploitation and female genital mutilation.
- We saw that the maternity and gynaecology guidelines about female genital mutilation were approved but the dates for completion and review had not yet been set on the document. We saw evidence that cases of female genital mutilation (FGM) had been reported correctly,

following the FGM guidelines. Cases of women under the age of 18 were reported to the police. The service engaged with the Milton Keynes Safeguarding Children Board and shared information with staff from the board on training days.

- The chief nurse of the trust had overall responsibility for safeguarding adults and children.
- There was a named safeguarding nurse who supported staff in the service whenever required. All staff we spoke to knew how to raise safeguarding concerns appropriately.
- All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns, must be trained in level 3 safeguarding. Overall, nursing staff in the maternity and gynaecology service had a safeguarding children level 3 training compliance rate of 96%. Medical staff had a compliance rate of 78% at the end of June 2016. The trust provided additional information which showed that the remaining eight members of staff had had training dates booked with 100% compliance due by the end of November 2016. Some junior staff who had had safeguarding training did not know what level they were trained to. Overall, trust wide compliance rate with safeguarding adults' training was 93% above the trust target of 90%.
- Level two and level three safeguarding training included training on child sexual exploitation (CSE). There was a study carried out by a senior registrar in 2015 at the hospital into identifying children at risk of child sexual exploitation that was used in a training session for doctors. The trust used a tool to help staff identify children who are at risk from CSE.
- The trust had a child and baby abduction policy, which reflected national guidance. The policy was due for review in May 2016 but this review had not yet been completed. The trust was aware of the document being overdue and took action to ensure this would be completed. Babies were seen to have correctly labelled identity bracelets on with an ankle and on a wrist.

Mandatory training

- The service had an initial induction mandatory training programme that included basic life support, information governance, infection control, health and safety, fire safety, safeguarding children and adults, mental health act and mental capacity act, equality and diversity and manual handling. All staff undertook a mandatory induction week to the trust. This had a 100% compliance rate.
- Mental Capacity Act and deprivation of liberty training was part of the on-going mandatory training. There was a 98% compliance rate in this training.
- There was mandatory training in "PROMPT" (Practice Obstetric Multi Professional Training) this covers learning about obstetric emergencies. The training was carried out for multidisciplinary groups that included consultants, staff grade doctors (such as registrars and senior house officers) junior doctors and all grades of midwives. The training included classroom sessions and simulations of events.
- Hospital staff were trained in dealing with obstetric emergencies through the PROMPT training in pre-eclampsia, sepsis, maternal collapse and haemorrhage, breech presentation and shoulder dystocia. In a community setting, midwives were trained in post-partum haemorrhage, cord prolapse, shoulder dystocia, and calls to emergency services. Staff all said that the training was very relevant and useful.
- The programme was ongoing at the time of our inspection and the aim was to complete with all staff by October 2016.
- There were several mandatory training programmes in place to address learning points that have arisen from serious incidents. For example, cardiotocography (CTG) has been put in place as a mandatory training course. Training had been put in place to improve safety for pregnant women and women in labour following several incidents. The service had implemented PROMPT training. This is a series of national training sessions that train multidisciplinary teams together in obstetric emergencies. The team included midwives, anaesthetists and doctors of all levels. Most staff gave feedback saying that the PROMPT course content was relevant to them and was effective in understanding and assessing patient risk and safety.

Assessing and responding to patient risk

- At the antenatal booking appointment women, had a full assessment of physical, social and mental health needs carried out. They were then allocated either consultant or midwife lead care, depending on their needs. Systems had been changed to make sure that

midwives and obstetricians were fully aware of which patients would be under their care. This ensured women with risk factors were seen by appropriately trained professionals.

- The services records showed 88% of women were booked in before 12 weeks and six days. The trust target was 95%. Senior managers told us that the paper system was in use was being revised to improve the booking times performance. There was an electronic patient records system currently under development that would further improve communication from the community to the hospital; this was anticipated to be use towards the end of 2017.
- All midwives were involved in the triage process. A woman could telephone, or arrive on the antenatal assessment unit or labour ward and be assessed and triaged by any of the midwives on duty. We saw the policy about maternity triage, which had clear guidelines on the criteria of admission and treatment of women to the maternity unit. The policy was evidence based and referred to Royal College of Obstetricians and Gynaecologists guidelines regarding preterm premature rupture of membranes (PPROM), foetal movement guidelines and foetal monitoring guidelines. All staff told us that if they were unsure of their assessment that they felt confident in seeking advice from more senior colleagues.
- Central CTG monitoring had been introduced so all women being monitored could be observed from outside the room by other team members as required.
- A maternity early warning score (MEWS) assessment record was used to detect signs of deterioration. This allowed staff to recognise the deteriorating patient and when to escalate any concerning observations to senior staff. Staff were trained during induction on the use of the early warning score. The service used audits to monitor the use of the MEWS. In May 2016, performance was 99% above the trust target of 90%.
- Generally, MEWS charts we looked at were competed accurately, however, in one set of records, there was a failure to record a patient's MEWS score. In another set of notes of a patient who required monitoring after an epidural, there was no record that this had been done. We brought this to the attention of senior staff at the time of the inspection.
- A system of fresh eyes, fresh ears had been introduced when women were in labour. This provided a second opinion of a baby's wellbeing whilst the woman was in established labour. A system of intentional rounding was in place on the labour ward. This meant that a senior midwife on duty would visit every patient in the labour ward two hourly to support them and the midwife caring for them. In June 2016, an audit was carried out the see if intentional rounding was taking place as required the most recent audit of intentional round carried out, we saw that intentional rounding was fully completed in 70% of cases and partially completed in 30% of cases. The findings of this audit were escalated to the maternity improvement board and actions plans put in place to improve performance in this area.
- Staff told us that if they escalated concerns to a senior midwife or a doctor they would usually get a quick response. If one doctor was busy and unable to come, they would escalate to a more senior colleague. The service had identified appropriate escalation of concerns as a learning point and a senior midwife told us they were working with midwives to recognise when to escalate concerns appropriately. There was one incident in the three months prior to the inspection where midwives reported difficulties in obtaining response from a doctor.
- There were clinical leads for diabetes in pregnancy, paediatric and adolescent gynaecology. There was also a team of 'vulnerable midwives' who had responsibility for parents who had been bereaved, mothers with mental health problems and mothers with a history of substance misuse. Senior midwives named safety and risk management of women as their highest priority.
- The service followed the trust's sepsis policy, which gave guidance to staff to diagnose and treat sepsis quickly. The service also had a policy entitled 'Pyrexia during Antenatal, Intrapartum and Postpartum Period'. Both policies conformed with the national recommended guidance, but we saw that the sepsis policy was due for review, which the service was aware of. In the period from December 2014 to December 2016, there had been no reported cases of sepsis.
- Women, who had had caesarean sections were prepared for surgery, had consented and had the risks of surgery explained to them. Pre-operative checklists were fully completed. This was in accordance with the World Health Organisation surgical checklist "Five Steps to Safer Surgery". We asked patients about their

experiences and they told us that they felt that they had fully understood the process, had all their questions answered and felt that they and their partners were fully involved.

- In three sets of nursing records, there was no venous thromboembolism assessment completed. In all sets of nursing notes we viewed, there was no completion of the record that anti- embolic stockings were observed to be on the patient. (Anti-embolic stockings are used to prevent blood clots in the legs). We escalated this to the trust, who took immediate actions to address this.
- There was no dedicated high dependency unit in the maternity department due to lack of space. A senior midwife told us that the department had recently ordered and received equipment to support women with high dependency needs and staff had been identified to be trained as high dependency midwives. Training places had been arranged. In addition, high dependency protocols were being developed. This meant that despite the lack of a dedicated space, women could begin to receive high dependency care on the labour ward when all the relevant staff and equipment were in place.

Midwifery and gynaecology staffing

- Staffing levels, skill mix and caseloads were generally planned and reviewed so that patients received safe care and treatment at all times, in line with relevant tools and guidance. Actual staffing levels met the planned levels at the time of the inspection. Arrangements for using bank, agency and locum staff kept people safe at all times, including ensuring appropriate induction processes were completed. The service did not use a specific tool for planning services according to patient acuity The National Institute of Health and Care Excellence (NICE) provides information about an acuity tool: Birthrate Plus® Workforce Planning Methodology and Birthrate Plus® Intrapartum Acuity Tool. This NICE guidance states, “The resource encourages the use of professional judgement in the final determination of maternity safe staffing levels in line with the guideline”.
- Over April, May and June 2016, there was a midwife fill rate of 96.6% in the day and 94% at night. This meant on most shifts that the maternity unit was slightly understaffed. However, the service had appropriate escalation plans to inform senior managers of staffing shortfalls and at times of peak demand, staff were flexed from the community service when required.
- We saw that in the year 2015 to 2016, and the year to date in 2016, 100% of women were provided with one to one care in established labour. On the labour ward, there was a policy of providing one to one care for women in established labour. This meant that a named midwife should be present, in the room, at all times, except for brief comfort breaks. The unit had developed the policy so that midwives could have a stool and drinks and light refreshments in the room to enable them to stay with a woman in labour at all times.
- The service used agency or bank staff to make up for any gaps in permanent staff. Evidence that showed throughout the service, the average use of agency midwives and nurses staff was around 12 percent of these staff hours. Induction processes were in place to ensure agency staff received appropriate information and orientation to the areas that they worked. Senior staff said the agency supplying the midwife and the midwife themselves were responsible for checking that they had the necessary skills and qualifications, however, there was not a systems in place by which the service checked the individual competency of all agency staff.
- On the days of our inspection at handover and throughout the day, the maternity department was continuously assessing what level of staff they needed in each area. This would depend on the level of care each ward needed as a whole. The different areas of the maternity unit worked together to make sure that all the women in their care had safe levels of suitably qualified staff looking after them.
- The midwife to birth ratio was 1:30 against the nationally recommended 1:28 ratio by the Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologist 2007). The service had reviewed this staffing ratio and it had been agreed by relevant commissioners.
- Senior staff said recruitment was ongoing and that jobs had been offered to all the newly qualified midwives on the most recent course. They would be starting in their roles in September 2016.
- The SAU where gynaecology patients were cared for had 24 beds and there was no specific number of

gynaecology beds allocated. Gynaecology nurses were available on each shift. The early pregnancy unit, which cared for women who were up to 18 week pregnant, was staffed by three gynaecology nurse specialists.

- On our inspection, there were delays of several hours and in some cases days, for seven women who had arrived in the unit for commencing induction of labour. This was because the labour ward was at full capacity and there was no-one to provide one to one care for additional woman in established labour. Staff said that there were sometimes staff shortages and therefore inductions of labour could be delayed. Women who go over 42 weeks of pregnancy have increased risks to the unborn baby. If a woman's waters have broken at or after 37 weeks of pregnancy and induction of labour is delayed, there is an increased risk of sepsis to both mother and baby. We observed managers assessing the priority of each patient, communicating reasons for delays to patients and at all times ensuring patients remained safe. We saw no evidence of impact on patients' safety due to the these delays during the inspection.
- The medical and midwifery staff were managing the bed capacity in the unit throughout the day. Senior managers were kept informed of the staffing position regularly throughout the day and the service had escalation plans to address urgent concerns. Patients who had had their inductions delayed told us that they had been informed of the bed situation.
- The maternity unit had carried out an audit of call bell response times in May 2015. This showed that the average response time to a call bell on labour ward was 32 seconds, on ward 9, 45 seconds and on ward 10, 54 seconds. This meant that women were quickly responded to if they needed help and reflect the fact that staffing levels met patients' needs at these times.
- Handovers that we saw were detailed and provided appropriate information about patients' needs and potential risks.

Medical staffing

- With a birth rate of nearly 4000 births per year, the recommended consultant presence on labour ward was 60 hours per week. The service covered the maternity unit with 65 hours of consultant cover per week. However, this was not necessarily a physical presence on the maternity unit as the consultants would be responsible for other areas of the maternity and gynaecology service at the same time. This meant we were unable to calculate the actual hours that a consultant was physically present on the maternity unit. The service was aware of this risk and was monitoring the position.
- There were 10 consultant obstetrician/gynaecologists employed by the trust. One of the consultants was away on a medium term sabbatical and this position had been covered by a locum consultant. A system was in place for providing locum doctors with an appropriate induction.
- The medical rotas and cover for the labour and gynaecology wards showed appropriate levels of emergency and on-call cover provided by different grades of doctor.
- There was a newly created on call rota for gynaecology which meant that all gynaecology patients were able to be assessed whilst patients in hospital by a suitably qualified consultant.
- Medical staff handed over to the next shift twice a day. The hospital had recently introduced a system known as "situation, background, assessment, recommendation" or 'SBAR' tool. This was used at handovers to ensure that all patients' conditions were fully handed over. We observed one hand over in the service where seven patients were discussed. The medical staff did not use the SBAR tool. In all of the cases discussed, none had their situation or background shared. The handover assumed that the incoming team had prior knowledge of the patients. We raised this with a senior manager who told us they would ensure that the SBAR tool was embedded in practice.
- Two junior medical staff said that some handovers could be 'chaotic'.
- There was no dedicated obstetric anaesthetist for the service. The hospital provided anaesthetic cover from within the anaesthetic department but at times, an anaesthetist may not have been able to attend quickly to a woman in labour due to other demands, especially overnight. This meant that some women had to wait longer than 45 minutes for an epidural anaesthetic in labour. Safer childbirth recommendations from the Royal College of Obstetricians and Gynaecologists (RCOG) 2007 states, "When women choose epidural analgesia for pain relief in labour they should be able to receive it within a reasonable time. This means that obstetric units should be able to provide regional analgesia on request at all times. In such units the

response time should not normally exceed 30 minutes and must be within one hour, except in exceptional circumstances Women and commissioners should be aware of those units where the epidural service is limited." Senior managers said that there was a national shortage of staff grade anaesthetists. Despite recruiting for several months, the trust had been unable to fill the post so plans were in place to rearrange anaesthetic staffing rotas to ensure obstetric cover was fully in place. The anaesthetic department had the shortage of anaesthetists recorded on the trust risk register.

Major incident awareness and training

- Potential risks were taken into account when planning services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing.
- The trust had an incident response plan. This was a trust wide document and whilst it had no reference to maternity services, there was a 'Maternity Escalation, Unit Closure and Business Continuity Plan'. This was a clear plan to manage high levels of patient activity and times when the maternity unit was full to capacity. Roles and responsibilities were clearly defined and processes for decision-making identified.
- Checks of fire extinguishers and emergency lighting had taken place at regular intervals.
- Partners staying on maternity wards with their partners overnight were requested to sign in to the ward so a record could be kept of who was there for fire evacuation purposes.

Are maternity and gynaecology services well-led?

Good

Overall, we rated the service as good for well led because:

- The trust had established an improvement board to review incidents and risks and to drive improvements in the service. Information was used to develop the service and continually improve. The service was focused on continuous improvement.
- There was a clear vision for the service and staff understood the trust's values.
- Leadership was well defined and visible. Leaders had been appointed in all the maternity and gynaecology sub specialities with clear work plans and objectives.
- Midwives and gynaecology nurses' roles had been developed to support the service and provide a greater level of expertise for patients.
- Governance, risk management and quality measurement systems were in place and used to monitor and improve safety, treatment and outcomes for patients.
- The culture within the nursing and midwifery teams was caring, supportive and friendly. All nursing and midwifery staff we spoke to told us that they were happy at work.

However, we also found that:

- External, regional health service planning had affected the service's development plans.
- In the maternity service, some examples were shared with inspectors of poor communication, inappropriate behaviours and lack of teamwork at consultant level within the service. From discussion with senior managers, it was clear that some issues had been recognised and active steps were being taken to optimise communication and team working. Such behaviours were not observed during the inspection.
- The service website information was very limited.

Vision and strategy for this service

- Senior leaders said that there was a vision for maternity and gynaecology services to be brought together and expanded to include a midwifery lead unit, and a high dependency unit. Also, there were plans for a more comprehensive gynaecology unit with a team of nurses who would provide outpatient and inpatient care and advice in suitable accommodation.
- The local commissioning group had been reviewing the provision of services at Milton Keynes and another local acute trust with a possibility of reconfiguration of maternity services. This work had been included into the local 'Sustainability and Transformation Plan'.
- NHS England had issued NHS Shared Planning Guidance 2016/17 to 2020/21. This states that all NHS organisations are asked to produce two separate but interconnected plans:
  - 1. A local health and care system 'Sustainability and Transformation Plan' (STP), which will cover the period October 2016 to March 2021; and

- 2. A plan by organisation for 2016/17.

- This meant that although the service had a vision and local strategy for a more developed service, until the STP plans were fully in place, no further local planning could go ahead.
- All leaders and staff told us they would like a midwifery led unit but understood that due to building and finance limitations there was not a realistic prospect of this being achieved until after the regional review. There was no dedicated midwifery led unit within the maternity and gynaecology service. Both midwives and senior medical staff told us that it would benefit women to have a midwifery led unit and increase patient safety. Leaders told us that plans for the development of the service were on hold due to the early stages of planning for maternity services across the region. The service was reviewing the local plans to provide a midwifery led unit and a high dependency unit areas in the delivery suite. The service was awaiting the outcome of the Milton Keynes and Bedford health services review as part of the potential trust-wide hospital configuration.
- There was evidence of extensive change that has taken place in the department over the last 21 months since our previous inspection and a review carried out in October 2014 by the Royal College of Obstetricians and Gynaecologists (RCOG) This included the following:
  - The clinical lead for obstetrics and gynaecology had appointed consultant leads in the following areas; minimal surgery (laparoscopy), colposcopy, cancer, fertility, uro-gynaecology, Early Pregnancy Assessment Unit (EPAU), governance and investigations, foetal medicine.
  - Gynaecology nurses were being trained in early pregnancy scanning. This would free up sonographers time for more complex Doppler scanning and consultants for complex foetal anomaly scans.
  - The trust provided women with gestational diabetes clinics in the antenatal department rather than the diabetic clinic, which was be a more suitable environment than a general outpatients' clinic.
- The trust had introduced new work plans for consultants to address some of the concerns about lack of cover in some areas.
- Staff at all levels were aware of the trust's values and most staff understood the service's strategy and the impact of the regional review on future plans.

Governance, risk management and quality measurement

- Robust arrangements for identifying, recording, and managing risks, issues, and taking mitigating actions were in place. There was a maternity and gynaecology risk register. Safety concerns and plans were set against a variety of risks including staffing, environment, and training needs. Generally, risks had clear timescales for action and a dedicated owner and the register was reflective of the risks found on our inspection.
- There were extensive governance and audit processes in place. Senior managers regularly reviewed patient safety and quality treatment indicators, the quality of care provided, patients' outcomes and any reported incidents. They identified gaps in the service and worked towards continually improving the service. All key safety and quality indicators were reviewed at the two monthly maternity improvement board.
- The senior managers we spoke to recognised that there had been poor quality reporting and investigation of incidents in the past. A consultant and specialist midwife had been appointed to lead improvement in this area.
- We saw that there had been extensive changes and implementations to the service over the last two years. This included training as a response to serious incidents and appointments to consultant leads in areas such as minimal surgery (laparoscopy), colposcopy, cancer, fertility, uro-gynaecology, Early Pregnancy Assessment Unit (EPAU), governance and investigations and foetal medicine. New work plans had been introduced and were under further review.
- There were monthly trust wide governance meetings and weekly maternity risk governance meetings. Monthly maternity and gynaecology service mortality and morbidity meetings were held. These meetings discussed recent cases of illnesses and deaths so that lessons were learned and shared with all medical staff.
- We saw an example of a weekly notice sheet with areas for improvement detailed that was discussed at every midwifery handover on the labour ward. This gave examples of how leaders were working to improve the quality of care women received.
- The majority of polices had been reviewed in date: however, we saw that some policies; such as the discharge policy and the nurse clinical supervision policy were requiring a review.

- The department had an extensive audit programme of both externally required audits and internal mandatory audits. These audits were reported and used to inform training and improvement within the service. There was a documentation audit of invasive procedures in maternity services. Gynaecology services had a forward audit plan.
- There was a maternity and gynaecology work plan in place with specific actions for the department lead and individuals in the service.
- The obstetrics and gynaecology department used the national safety standards for invasive procedures to develop local standards for invasive procedures. The maternity and gynaecology service had a policy in place to ensure that termination of pregnancy care and treatment were provided in accordance with the Abortion Act 1967.
- Departmental leaders clearly saw safety and patient experience as their top priority.

Leadership of service

- There was clear leadership throughout the service from board to doctors and midwives. We saw evidence of accountability and responsibilities at each level. Midwives we spoke to were aware of their role and responsibilities and their professional requirements according the code of practice for nurses and midwives. We saw job plans for all the consultants within the department that were agreed and signed off.
- The service leaders provided examples of how working practices had been changed to reduce risks to pregnant women and women in labour following lessons learned from incidents. For example, there was now a simpler way of assessing whether a woman should have consultant or midwife lead care. This would help to prevent failure to escalate women who develop risk factors.
- Senior managers gave us examples of training that had been put in place following recognition of some areas of practice that required improvement. For example, the measuring of fundal height (the size of a pregnant woman's womb) to determine whether or not a baby was growing as expected.
- Staff spoke highly of the experience and integrity of the senior management team in the maternity and gynaecology department.
- Staff told us that the divisional lead was approachable and visible in the service. The head of midwifery was highly visible and was frequently on the maternity unit.
- All midwives were appointed a senior midwife and supervisor of midwives to support them in practice. They could go to any senior member of support for immediate advice and guidance as required.
- The head of midwifery worked closely with the clinical lead in maternity and gynaecology, director of operations and the medical director. We saw evidence from minutes of meetings showing ongoing and clear communication.
- Staff said that the visibility of senior staff on the surgical assessment unit, where gynaecology patients were treated, was infrequent.
- The service worked with supervisors of midwives and with the Head of Midwifery by meeting once a month. Service developments, improvements and midwifery issues were discussed. Supervisors contributed to the meetings.
- Staff said the chief nurse was supportive and visible in the service
- There was no non-executive director at the trust responsible for maternity services.

Culture within the service

- The service was addressing difficulties in the effective working relationships and communication within the medical staff team. Several members of staff told us that they had seen an improvement in communication, but more could be done. Several staff told us that patient care plans could change with a change of consultant, which could lead to confusion from the patient's point of view. Several staff told us that some consultants would undermine others. These concerns had been reported through the reporting system. This had been referred where necessary to outside bodies for further investigation. Staff said there was not a cohesive team environment amongst the consultants. Senior managers were aware of this issue and were taking actions to address the concern. Leadership courses were now provided and team building events were being planned.
- Most staff told us that they were happy working in the service. Midwives in particular told us that they enjoyed working in a close team and all members played their part in supporting one another. Midwifery staff told us that over time they had begun to feel more valued.

- Midwifery staff were rewarded with a special mention in a newsletter if they achieved excellence in record keeping. Midwifery staff told us that there was a supportive atmosphere. This group of staff told us there was a no blame culture and feedback was available if requested via the reporting system, however sometimes this feedback did not happen and sometimes it was unhelpful and did not address the incident report.
- Staff told us that the matrons were very approachable and mostly visible. Senior managers addressed performance and behavioural issues. Leaders, senior managers, matrons and midwives all put the patient in the centre of what they do. Midwifery matrons told us that they encouraged staff to come to them with concerns and worries. Medical staff told us that the midwifery staff work very hard. The ward managers (band 7 midwives) were highly regarded and respected and "helped keep it together".
- A specialist bereavement midwife was available to support staff. All midwifery staff at all levels had appropriate access to pastoral support as needed. There was limited pastoral support in the medical profession, despite some recent highly stressful events.
- A senior leader of the service told us that there was very little emotional support for doctors of all levels within the service. The trust told us that it provided a number of services to support staff including chaplaincy, occupational health, a counselling service, clinical supervision and debriefs following difficult situations.
- Since the last inspection, and with the issuing of a report from the Royal College of Obstetrician's at the same time, there had been implementation of programmes to support cultural change within the service. This included a cultural development programme for staff. The trust had introduced the Royal College Of Obstetricians and Gynaecologists (RCOG) "STOP IT" course to raise awareness of behaviours which constitute bullying, harassment and intimidation and to manage these issues constructively
- The trust is a university teaching hospital therefore there were strong links with the University of Buckinghamshire and the deanery. (A deanery is a regional organisation responsible for postgraduate medical and dental training). There were also strong links with the University of Bedfordshire that delivered nurse and midwifery training.
- Doctors at all levels were involved in continuous learning. This was done by on the job training, more formal weekly training sessions, audit meetings, perinatal meetings and cardiotocography (CTG) training. They also engaged in national lead training and regional weekly training sessions.
- There was a practice development team including a midwife who was responsible for ensuring all mandatory training was delivered and attended. The practice development midwife also developed appropriate learning opportunities to benefit patients, the hospital and individuals.
- The Practical Obstetric Multi-Professional Training (PROMPT) training was delivered in multidisciplinary teams to promote shared understanding.
- A minority of medical staff said that the incident reporting culture was improving but at times felt nervous about reporting incidents as they felt they would be blamed.

Public engagement

- The service engaged with the public in a variety of ways. The results of recent "friends and family tests" were displayed. The Friends and Family Test is a way of gathering patient feedback about their experiences and helping to drive improvement in hospital services. In June 2106, 92% of people surveyed said that they would recommend the maternity service overall. In this survey there was a 70% response rate.
- In some areas, such as the labour ward, the response rate was as low as 5%. The service was looking at ways to improve this response rate.
- Other ways the trust engaged the public was through the Maternity Services Liaison Committee (MSLC). Service users, maternity service staff and community groups met regularly to discuss improvements in maternity services. We saw minutes of these meetings, which detailed of how the patients' voices were heard and acted upon.
- The service also had started a project, called "Maternity MK", to continue to raise the profile of the service, to generate interest, awareness and support from the hospital staff, commissioners, relevant agencies and external organisations, such as the local Healthwatch, and people in the local community.
- There was very limited provision of information for the public on the trust website about the maternity service and the range of options it provided.

Staff engagement

Maternity and gynaecology

- We saw effective staff engagement at all levels from the board to senior leadership team, matrons to senior nurses and senior nurses to junior nurses.
- We saw that the department of obstetrics and gynaecology listened to the concerns of the staff and created ways of improving working conditions and support for staff. For example, a staff attitude questionnaire highlighted concerns about working environment and communication. The service had put in place a cultural development programme and offered leadership training to staff to help improve this.
- The trust had a project called "We Care". The project set standards and commitments for the trust and its employees. The service aimed to ensure patients and colleagues alike were always treated the way everyone would like for their families and themselves.
- Staff were encouraged to complete incident forms to help individuals, the department and the hospital learn from experiences and were confident that their concerns would be listened to and acted upon.
- Staff told us that they appreciated flexible working and that the service was helpful and amenable to all such requests.

Innovation, improvement and sustainability

- The trust had a clear governance structure and the leaders of the trust were committed to continuous learning, improvement and innovation. They did this by providing appropriate education and training in areas that have been identified by incidents. They also employed practice development teams and used strong links with universities and regional forums.
- Senior managers were working with consultants to encourage practice development for the benefit of patients.
- We saw evidence that the Bedfordshire and Milton Keynes health care review that planned to reorganise maternity services between Bedford and Milton Keynes, was transferred into the Sustainability and Transformation Plan (STP). This was a five-year plan to manage services for the populations of Bedford, Luton and Milton Keynes. This meant that plans to reconfigure maternity services in the region were on hold pending further review.
- There was no financial provision for improving the maternity facilities at the trust.
- Although there was a shortage of a dedicated obstetric anaesthetist, there was financial provision for this post.

End of life care

Safe	Good
Overall	Good

Information about the service

We carried out a focused unannounced inspection on 12, 13 and 17 July 2016 following our previous comprehensive inspection in October 2014. During the previous inspection, we found that end of life care overall was good and that specifically, the key question of safe required improvement.

Patients with end of life care needs are nursed on the general wards throughout the hospital. They are supported by a consultant-led specialist palliative care team (SPCT). This team provides specialist advice and support as requested and coordinates the planned care for patients at their end of life on the wards. Ward 22 is used to care for the majority of patients requiring end of life care as it has a number of side rooms appropriate for this purpose.

The service has seen an increase in the numbers of in patients referred and reviewed by the team from 425 (April 2013 to March 2014) to 670 (April 2014 to March 2015). The number of deaths of patients on the team's caseload from April 2015 to March 2016 was 360.

The specialist palliative care team works Monday to Friday 8.30am to 5pm. An on call service operates at the weekends and out of hours.

We visited a range of wards, including ward 22 (haematology), ward 2 (the short stay unit), ward 1, ward 16 (medical wards), the Macmillan day unit (which provided a day service for haematology and oncology treatments) and the mortuary. We spoke with 20 staff, three patients, and reviewed 15 sets of patients' records, including 15 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms.

Summary of findings

Overall, we rated the service as good for safety. Significant improvements had been made since the October 2014 inspection. We inspected the safe key question for this inspection and we found that:

- Improvements had been made in the completion and review of patients' 'do not attempt cardio pulmonary resuscitation' forms.
- Staff knew how to report incidents appropriately, and incidents were investigated, shared, and lessons learned.
- Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- There were effective systems in place regarding the handling of medicines.
- Equipment was generally well maintained and fit for purpose.
- Chemicals hazardous to health were generally appropriately stored.
- Risks in the environment and in the service had been recognized and addressed.
- Staffing levels were appropriate and met patients' needs at the time of inspection.
- Patients' individual care records were written and managed in a way that kept people safe
- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Mandatory training was provided for staff and compliance was 100%.
- Records were accurate, well maintained and stored securely.
- Appropriate systems were in place to respond to medical emergencies.
- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.

End of life care

Are end of life care services safe?

Good

Overall, we rated the service as good for safety. Significant improvements had been made since the October 2014 inspection. We found that:

- Improvements had been made in the completion and review of patients' 'do not attempt cardio pulmonary resuscitation" forms.
- Staff knew how to report incidents appropriately, and incidents were investigated, shared, and lessons learned.
- Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- There were effective systems in place regarding the handling of medicines.
- Equipment was generally well maintained and fit for purpose.
- Chemicals hazardous to health were generally appropriately stored.
- Risks in the environment and in the service had been recognized and addressed.
- Staffing levels were appropriate and met patients' needs at the time of inspection.
- Patients' individual care records were written and managed in a way that kept people safe
- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Mandatory training was provided for staff and compliance was 100%.
- Records were accurate, well maintained and stored securely.
- Appropriate systems were in place to respond to medical emergencies.
- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and how to report them. When things did go wrong, thorough and robust reviews were carried out. The service was focused on learning lessons to make sure action was taken to improve safety.
- An appropriate range of safety information was being monitored by the service.
- There had been no never events reported for this service in the past year. A never event is described as wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- No incidents relating specifically to end of life care had been reported in the current year.
- The trust had an incident reporting system in place and standard reporting forms for staff to complete when something went wrong. Records seen demonstrated staff had acted upon incidents that had occurred. Staff told us that reported incidents were sent to the trust head office and discussed at staff meetings when necessary. Staff received feedback on incidents and action taken via staff meetings, team briefings and information on staff noticeboards.
- Staff meetings were held monthly and learning from incidents was a regular agenda item. This was where the wider learning points from an incident were disseminated and any necessary change in protocol discussed and passed to all staff. There were processes in place for the team to review all of the deaths in the hospital at morbidity and mortality review meetings.
- Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been no accidents or incidents which had required notification under the RIDDOR guidance in the last 12 months.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person.

End of life care

- Staff described a working environment whereby they would investigate and discuss any duty of candour issues with the patient and their family and/or representative and an apology given whether or not there had been any harm. We saw that appropriate guidance was in place for staff.
- Staff at all levels were able to explain the changes in regulations to Duty of Candour and their responsibility to deliver a timely apology when there was a defined notifiable patient safety incident.
- The service had carried out risk assessments and implemented policies and protocols with a view to keeping staff and patients safe.
- There were no direct complaints made regarding the hospital palliative care team during the year April 2014 to 2015, however there was a complaint that involved the hospital palliative care team, as part of a larger concern, which was investigated in a timely manner and used to facilitate learning across teams.
- The service had introduced some key performance indicators that were reported in a clinical dashboard. One of these measures was to assess referral rates and referrals showed an increase from 40 cases a month to currently 90 a month at the time of inspection. Other indicators being measured and reported were time for assessment following referral, which was 100%, within the trust target of 48 hours at the time of the inspection, and average length of stay.
- The trust had an end of life steering group led by the executive lead for end of life care which reviewed all safety and quality information about the service.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- The wards, waiting areas, and clinical treatment areas visited all appeared to be visibly clean and tidy and free from clutter.
- Hand sanitising gel dispensers were available in corridors, waiting areas and clinical areas. Staff were observed using hand sanitisers and personal protective equipment as appropriate.
- We saw that wards and departmental staff wore clean uniforms with arms bare below the elbow and personal protective equipment (PPE) was available for use by staff in all clinical areas. Supplies of PPE were readily available in all clinical areas to aid effective infection control. We saw audits were carried out on the wards we visited for hand hygiene which reported compliance at 90% and above.
- We saw that wards and departmental staff wore clean uniforms with arms bare below the elbow and personal protective equipment (PPE) was available for use by staff in all clinical areas. Supplies of PPE were readily available in all clinical areas.
- The segregation and storage of waste was in line with current guidelines laid down by the Department of Health. We observed sharps containers, clinical waste bags and municipal waste were properly maintained and this was in accordance with current guidelines.
- We saw that biohazard (body fluid) spillage kits were available if needed.
- 'I am Clean' stickers were placed on equipment including toilet seats and the resuscitation trollies so equipment viewed on the inspection was safe for use.
- The mortuary generally had effective systems in place to minimise the spread of infections. Appropriate guidance was in place for maintaining a clean environment and reducing the risk of infection.
- On our unannounced visit, we found that the sink in the sluice room contained a large number of items, some sterile and some that had been used. Staff told us this was due to new flooring having been laid. We reported this to senior staff, who took immediate action to rectify this. The day after our visit, the trust carried out a thorough infection control audit of the mortuary and put a series of actions in place to address the concern.
- Staff training for infection control showed 100% compliance.

Environment and equipment

- Generally, the design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment kept people safe. Risks had been identified by the service and actioned.
- We saw that the wards we visited were clean, bright and well maintained. Surfaces and floors in patient areas were covered in easy to clean materials which allowed high levels of hygiene to be maintained throughout the working day. We saw throughout the clinical areas, the general and clinical waste bins were covered with foot opening controls and the appropriate signage was used.
- There were arrangements in place to meet the Control of Substances Hazardous to Health Regulations 2002

(COSHH). COSHH is the legislation that requires employers to control substances which are hazardous to health. We saw in ward areas that cleaning materials used by the cleaners were stored in locked rooms in clinical areas we visited. In the mortuary, we found not all chemicals hazardous to health were locked in secure storerooms as was trust policy. Senior staff immediately took action to address this and to ensure this was monitored.

- The arrangements for managing waste and clinical specimens was appropriate. This included the classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.
- There were systems in place to check and record equipment was in working order. These included annual checks of electrical appliance testing of electrical equipment. The trust had contracts in place with external companies to carry out annual servicing and routine maintenance work of other equipment in the premises in a timely manner. This helped to ensure there was no disruption in the safe delivery of care and treatment to patients.
- Electrical safety checks had been carried out on mobile electrical equipment and labels were attached which recorded the date of the last check.
- There were clear guidelines for staff about how to respond to a sharps injury (needles and sharp instruments). The service used dental safety syringes which meant needles were disposed of safely. This complied with the Safe Sharps Act 2013.
- The McMillan day unit had achieved the McMillan Environmental Quality Mark in 2010 and had been re-accredited in 2014. This area provided a comfortable and well equipped environment for patients and their relatives. Facilities met patients' needs.
- Ward 22 was the main ward where patients needing end of life care were admitted as inpatients. This was because the ward had 14 side rooms, which provided greater privacy and dignity for those patients needing end of life care. We checked the resuscitation trolley on this ward and found it was fit for use and that daily checks had been recorded.
- Syringe pumps were available. There was an effective tracking system in place when patients were discharged from the hospital with a syringe pump.
- The mortuary had a viewing suite where families could visit their relatives. We visited this area and saw that the viewing suite had a separate waiting and viewing room.
- The mortuary waiting room was clean, modern and provided facilities for relatives, such as comfortable seating, tissues and information booklets about bereavement and the trust's bereavement service. The suite contained no religious symbols, which allowed it to accommodate people of all religions.
- The mortuary had appropriate facilities to store 50 deceased patients' bodies and also had bariatric storage facilities. On our unannounced visit, we found that two of the five body refrigeration stores were marginally above the recommended temperature range maximum of 5 degrees Celsius, but below the ceiling temperature threshold of 10 degrees Celsius, as recommended by the manufacturer and the Human Tissue Authority. We reported this to senior staff, who took immediate action to address this issue. The body stores did have an appropriate alarm system that would alert staff when the temperatures were too high.
- Ward 2 had piloted a dedicated bereavement box that contained appropriate equipment, soft lighting, and bed furnishings to provide a 'homely' environment for those patients requiring end of life care. The trust's infection control committee had approved the equipment and furnishings used. This was now being rolled out across other wards.

Medicines

- There were effective systems in place regarding the handling and storage of medicines.
- An effective system was in place for the prescribing, recording, dispensing, use and stock control of the medicines used. The records we viewed were complete, and provided an account of medicines used and prescribed which demonstrated patients were given medicines when required.
- Appropriate secure storage facilities were in place and wards were monitoring the temperatures of medication fridges and medicine store rooms.
- Cytotoxic medicines were stored safely and there were appropriate arrangements in place for their disposal.
- There was guidance in place for the effective use of medicines that supported patients at the end of life.

This included pain relief and medicines to control nausea and vomiting. Information on what to prescribe was clear and it considered implications of giving medication to patients with impaired renal function
- The service had implemented a 'just in case' prescription process for prescribing anticipatory medicines at discharge in conjunction with the pharmacy department.
- The specialist palliative care team had worked with other providers of end of life care team within the area so there was consistent practice in relation to the prescribing of medicines at the end of life.
- A pocket guideline had been produced for medical staff which gave doctors an easy to follow guide based on evidence based practice.
- Controlled drugs were given in a timely way, and staff told us they prioritised this. Appropriate facilities were in place on the wards visited for the storage, handling and disposal of controlled drugs.
- Anticipatory medication was prescribed to meet patients' needs. This is medication that might be needed for patients who are at the end of life.
- We reviewed two drug charts for patients on ward 10 and found that they had been completed accurately and medicines had been given and signed for as per the prescription.
- We reviewed three drug charts on ward 22 and found no gaps or inconsistencies in the recording of medicines administered.

Records

- Patients' individual care records were written and managed in a way that kept people safe. Records seen were accurate, complete, legible, and up to date. Patient records were maintained in accordance with trust policy.
- Each patient contact with the service was recorded in the patient's care records and these records were completed at the time of treatment. They were legible, accurate and up-to-date.
- The SPCT had developed cards for end of life patients so that when they were admitted they would show the staff they were in receipt of end of life care.
- We saw evidence that the specialist palliative care team were reviewing records of patients who were at the end of life.
- We reviewed two patient records on ward 1 and four on ward 22 and found that all required nursing documentation had been completed accurately and in full and that the individual personalised care plans for the dying patients had been reviewed daily by the SPCT.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- Staff had regular training in safeguarding of vulnerable adults and child protection. Those interviewed were able to provide definitions of different forms of abuse and were aware of safeguarding procedures, how to escalate concerns and relevant contact information. Information on safeguarding was seen on staff noticeboards and in public areas with relevant contact numbers.
- The team had 100% compliance in safeguarding adults training (to level 2) and safeguarding children's training (to level 2).

Mandatory training

- The service had a mandatory training programme that included basic life support, information governance, infection control, health and safety, fire safety, safeguarding children and adults, mental capacity act, equality and diversity and manual handling.
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs. We saw completed training records for staff which meant that staff working across the services were supported with their local induction.
- The team had 100% compliance with the mandatory training requirements at the time of the inspection. We saw training records that showed when staffs' training was due to refreshed and that appropriate refresher training had been booked.
- Staff told us this training met their needs and they did not have any difficulties accessing training.
- Training for end of life care was now included in junior doctors' induction training to promote effective identification of those patients' requiring end of life care.
- The SPCT linked to all wards to ensure all staff end of life care training was in place and embedded.

- Mental Capacity Act (2005) training was provided as part of the trust's mandatory training for all new staff, and this was one or two hours long. The trust also provided an online e-learning module for staff to complete.

Assessing and responding to patient risk

- Staff said the SPCT would review a patient within 24 hours of a referral. Referrals could be made outside of normal working hours to the on call palliative care nurse: these patients would be prioritised for review for the start of the next day. Referral criteria were in place to provide staff with appropriate guidance on making referrals to the team.
- A dedicated form was completed by ward staff when they required a rapid response to the deterioration of an end of life care patient. These referral forms contained appropriate information to enable urgent assessments to be carried out. A discharge checklist was used to ensure all aspects of patients' needs, including the provision of appropriate equipment, were considered before discharge.
- The hospital had a daily safety huddle meeting at 8.30am in the weekday mornings which the specialist palliative care team attended. We observed one of these huddle meetings and saw that patients on all wards who were at the end of their life were identified and discussed so the SPCT could review these patients on the wards in a timely manner.
- An electronic tracking tool was in the process of being developed to have a contemporaneous record of all patients requiring end of life care. Staff said it was anticipated this would be in place within the next four months.
- At the last inspection, we found inconsistencies in the way that patients 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms had been completed. We reviewed 15 DNACPR forms on this inspection and found that almost all had been completed in accordance with trust policy.
- Staff told us that doctors usually completed mental capacity assessments for patients and that the outcomes of the assessments were recorded on the patient's medical notes.
- On ward 2, we reviewed five patients' DNACPR records and found that four were completed in accordance with the trust policy. One patient's DNACPR had been conducted in the community, prior to admission to the hospital. It had not yet been reviewed by the medical team in the three days since the patient's admission. We brought this to the attention of senior staff, who immediately arranged for it to be reviewed during the course of our inspection. There were clear records of the patients' mental capacity and discussions with the patient (where appropriate) and their families recorded in the medical notes. Forms had been completed by an appropriately competent senior member of staff and had been countersigned by a consultant within the trust specified timescale of 24 hours.
- On ward 11, we reviewed three patients' DNACPR forms and found that they had been completed in accordance with trust policy and that there was a clear record of the patients' mental capacity in the medical notes and evidence of discussions with the patients'' families.
- On ward 22, we found that five patients' DNACPR records had been completed in accordance with trust policy and there was documented evidence of discussion with patients and families.
- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. The service used the National Early Warning Score (NEWS) system for identifying and escalating deteriorating patients. We reviewed four NEWS charts on ward 22 and found these were completed appropriately with evidence of escalation when required.
- The trust had recently issued an end of life care policy (on 1 July 2014): it had replaced the Liverpool Care Pathway with a new plan called the personalised care plan for the dying patient. The trust based the policy on quality standards produced by the National Institute for Health and Care Excellence (NICE) for improving care for patients at the end of life. It was also based around the Leadership Alliance for the Care of Dying People's report One Chance to Get it Right: improving people's experience of care in the last few days and hours of life (2014).
- The trust's Macmillan service had an effective relationship with the SPCT and ensured that patients nearing the end of life were referred to the team in a timely fashion. Staff told us that patients referred to the SPCT were seen within 24 hours of referral and reviewed on a daily basis.
- Trust-wide audits of 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were carried out and results communicated back to all wards. The audit in October 2014 included a review of completion of

DNACPR forms and whether clear evidence of discussions with patients and their families had been recorded in patients' notes. The forms had been completed in 100% of cases reviewed with clear identification of the clinician making the decisions in 98% of cases. Evidence of review was found in 20% of cases in this trust audit. An action plan was in place to continue to improve compliance with trust policy and was progress was being monitored by the team.

Nursing staffing

- Staffing levels, skill mix and caseloads were planned and reviewed so that patients received safe care and treatment at all times, in line with relevant tools and guidance. Actual staffing levels met the planned levels at the time of the inspection.
- The specialist palliative care nursing team comprised of a lead advanced palliative care nurse, three advanced nurse practitioners and end of life nurse and now had an administrator in post. The specialist palliative care team worked Monday to Friday 8.30am to 5pm. An on-call service operated at the weekends and out of hours.
- Staff told us there were always enough staff to maintain the smooth running of the service and there were always enough staff on duty to keep patients safe. We saw records that demonstrated staffing levels and skill mix were in line with planned staffing requirements for the planned service delivery. The trust had increased staffing in the team by the recruitment of an advanced nurse practitioner for end of life care, a senior lead nurse for palliative care and secretarial support.
- Arrangements for using bank, agency and locum staff kept people safe at all times, including ensuring appropriate induction processes were completed. There was minimal use of agency staff over the past year staff told us.
- The team also had a discharge facilitator linked to the palliative care service to promote appropriate and timely discharges from the hospital. Each patient would receive a review of their needs prior to discharge.
- The trust were using a patient acuity tool to link dependency of patients to staffing levels.
- All wards had capacity to be flexible with the staffing levels if the dependency of the patients increased. There was a clinical assessment process in place which was led and approved by the matron or if it was out of hours by the clinical site team. End of life care patients were identified at the daily safety huddle. This meant the senior leaders in the trust had oversight of how many patients needed end of life care on each ward.
- A daily team briefing meeting took place at 9am to review all new referrals and those patients requiring a review. This meant the team planned and prioritised their work daily based on referrals and demand.
- Palliative care nurses completed a ward round each Friday and reviewed all patients at end of life care to ensure effective arrangements were in place for the weekend.

Medical staffing

- The specialist palliative care team included a whole time equivalent consultant in palliative care medicine. The service provided consultant cover on site Tuesdays to Fridays. In addition, an associate specialist doctor provided medical cover on Mondays. This doctor worked the remaining sessions at the local hospice which was managed by a different provider. This meant there was some continuity of care between the patients moving from the hospital to the hospice. It also afforded opportunities to keep communication and networking open between the hospital and the hospice.
- Consultant-led ward rounds took place on Mondays, Tuesdays, Wednesday and Thursdays and all patients requiring end of life care would be reviewed on these ward rounds.
- The service had now embedded an on-call consultant service, working across the region with seven other acute trusts and a local hospice. Weekly multidisciplinary meetings took place each Wednesday to promote effective communication across all providers.
- Junior medical staff said there was raised awareness in the hospital regarding end of life care patients and that medical staffing levels were appropriate to ensure any requests for medical review were carried out swiftly.

Major incident awareness and training

- Potential risks were taken into account when planning services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing.
- Arrangements were in place to respond to emergencies and major incidents. A Business Continuity Plan was in place.

End of life care

- There was good understanding amongst staff with regards to their roles and responsibilities during a major incident. Staff were able to signpost us to the trust wide policy which was located on the trust intranet.
- Staff we spoke to were aware of the trust's policy and procedures for fire safety and said that regular fire drills were carried out as well as what to do should a major incident arise.
- For fire safety, 100% of staff had completed the trust's training within the past year.
- Checks of fire extinguishers and emergency lighting had taken place at regular intervals. We also saw records of fire drills and fire training within the last 12 months.
- The mortuary technicians told us they had a contingency plan in the event that the mortuary became full.

Outstanding practice and areas for improvement

Outstanding practice

The medical care service had a proactive elderly care team that assessed all patients aged over 75 years old. This team planned for their discharge and made arrangements with the local authority for any ongoing care needs.

The medical care service ran a 'dementia café' to provide emotional support to patients living with dementia and their relatives.

Ward 2 had piloted a dedicated bereavement box that contained appropriate equipment, soft lighting, and bed furnishings to provide a 'homely' environment for those patients requiring end of life care. The trust's infection control committee had approved the equipment and furnishings used. This was now being rolled out across other wards.

Areas for improvement

Action the hospital SHOULD take to improve

- Review and monitor the access and security of both the adult and paediatric emergency departments.
- Monitor the facilities available for respecting the privacy and confidentiality of patients and relatives during the booking in process in the adult and paediatric emergency departments.
- Monitor the initial clinical assessment times within the paediatric emergency department.
- Monitor that recommended checks are carried out on all resuscitation equipment and documented in the adult and paediatric emergency departments.
- Review and monitor the mental health assessment room to ensure it is fit for purpose in the adult emergency department.
- Monitor the effectiveness of staff, patient and relatives' adherence to infection control procedures within the adult and paediatric emergency departments.
- Monitor staff compliance with mandatory training requirement to meet the 90% trust target in the adult and paediatric emergency departments.
- Ensure that all resuscitation and emergency trolleys are fit for purpose and robust audits are completed.
- Ensure that agency staff have appropriate induction with evidence of completion.
- Review the isolation facilities available on Ward 17 for patients with infections.
- Review the storage of hazardous chemicals and needles to ensure that no unauthorised people could have access.
- Review the non-invasive ventilation policy, incorporating the new guidance available.
- Review the arrangements for timely discharge of patients from the AMU.
- Review the procedures for the management of outlying patients.
- Review the process for recording the number of bed moves for patients, including out of hours and at weekends.
- Review the specific arrangements for caring for patients with autism.
- Review the completion of assessments for venous thromboembolism (VTE) to ensure patients' safety needs are met.
- Review arrangements for monitoring the cleaning of equipment in the maternity service.
- Review the provision of pain relief provided to women in labour to ensure patients' needs are met.
- Review the arrangements for post-operative recovery to ensure mothers and babies can be cared for together, unless in emergencies.
- Monitor the safeguarding children's training provision for medical staff in the maternity service.