Milton Keynes Hospital NHS Foundation Trust

# Milton Keynes Hospital

## Quality Report

Standing Way
Eaglestone
Milton Keynes
Buckinghamshire
MK6 5LD
Tel: 01908 660033

Date of inspection visit: 22-23 October 2014
Date of publication: 06/03/2015

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** | **Requires improvement** |
| Urgent and emergency services | **Requires improvement** |
| Medical care | **Requires improvement** |
| Surgery | **Good** |
| Critical care | **Good** |
| Maternity and gynaecology | **Good** |
| Services for children and young people | **Good** |
| End of life care | **Good** |
| Outpatients and diagnostic imaging | **Good** |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Milton Keynes Hospital NHS Foundation Trust consists of one medium-sized district general hospital. The trust provides a full range of hospital services including accident and emergency, critical care, general medicine including elderly care, general surgery, paediatrics and maternity care. In total the trust has 508 hospital beds.

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.

Monitor is the independent regulator of foundation trusts in England. It issues licences to operate. In November 2014, Monitor issued enforcement undertakings on Milton Keynes Hospital NHS Foundation Trust because it was in breach of its licence. Breaches were in three areas: A&E waiting times, financial breaches (financial deficit) and governance (the failure to deliver the clinical risk management plan). The trust was taking steps to address these enforcement undertakings.

We inspected Milton Keynes Hospital NHS Foundation Trust as part of our comprehensive inspection programme. We carried out an announced inspection of Milton Keynes Hospital between 22 and 23 October 2014. In addition, an unannounced inspection was carried out between 5pm and midnight on 2 November 2014. The purpose of the unannounced inspection was to look at the accident and emergency (A&E) department and the general management of medical patients out of hours.

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 and responsive to people’s needs. Our key findings were as follows:

- Staff were caring and compassionate and generally treated patients with dignity and respect.
- The hospital was generally clean and well maintained. Infection rates were in line with England averages. We saw that staff washed their hands between patients.
- The trust had consistently not met the target for treating 95% of patients attending accident and emergency (A&E) within four hours. Plans were in place to address performance, and progress was being made. The hospital was under significant pressure for beds, and demand was exceeding the capacity.
- There were staffing vacancies in some areas, although the nursing and medical numbers had recently increased. We found some examples where staffing levels were not in accordance with the required levels, but escalation procedures were in place and risk assessments were being carried out. Patients told us that staff, particularly nurses, were very busy. We found some staff felt under pressure and were concerned that they were not able to deliver the care they wanted to.
- There were medical staff vacancies. Recruitment was underway and the trust reported that it was finding it easier to attract the best medical staff to the hospital because they were opening a new medical school.
- There were no open mortality outliers at the trust at the time of our inspection. Outcomes for patients were generally good and the trust was providing effective services.
- We saw that patients were given assistance to eat and drink, although fluid and food intake charts were not always completed. The catering department worked with dieticians and ward nurses to provide menu options for patients who required a different diet to that on offer.

We saw several areas of outstanding practice including:

- Sensory walk rounds had taken place in the wards and departments and had led to improvements for people who had visual impairments.

# Summary of findings

- The Cancer Patient Partnership group was providing the trust with an outstanding way of engaging with patients and the public. There was good engagement between staff and the members of this group which had led to improvements in patient care.
- The care delivered by staff working in bereavement teams was good, this included the care provided to women and their partners after a bereavement of a baby. The bereavement specialist midwife had recently won a national award for her work in the trust's maternity service.
- Leadership within surgery was "outstanding." There was a shared purpose, excellent relationships were in place and there were high levels of staff satisfaction. Staff were very committed to working together in order to improve quality for patients.
- Consultant medical staff were extremely engaged with the leaders in the trust and were very positive about the future for Milton Keynes Hospital.

However, there were also areas where the trust needs to make improvements.

The trust should:

- The trust should ensure that patients in the waiting area in the medical assessment unit (Ward 1) have a means of calling for urgent help if required.
- The trust should ensure that cytotoxic waste is always stored securely.
- The trust should ensure that full and accurate records are maintained in relation to the care and treatment provided to each patient. This should include accurate recording of venous thromboembolism risk assessments for all patients, dementia risk assessments for patients aged 75 years or over, and records of food and fluids for patients assessed at risk of inadequate nutrition and dehydration.
- The trust should ensure that there are suitable arrangements in place for all staff to receive appropriate training and appraisal.
- The trust should ensure that patients who need inpatient care and treatment are transferred from the medical assessment unit to an appropriate ward within 72 hours.
- The trust should ensure pre-operative safety checks are carried out in accordance with WHO for all types of surgery, including dental extractions.
- The trust should ensure patients' privacy and dignity is maintained with the A&E department.
- The trust should ensure the completion of DNACPR documentation is consistent across the hospital.
- The maternity and gynaecology governance team should ensure appropriate and timely monitoring, updating and checking for the completion of action plans that had resulted from serious incident investigations or root cause analysis to ensure lessons were learnt.
- The trust should consult with the trust's health and safety and fire teams to establish operational protocols for partners who remain on Ward 9 overnight.

In addition the trust should consider the following areas:

- The trust should consider working with their commissioners to ensure the service provided by the Child and Adolescent Mental Health team (CAMH's) is consistently providing a responsive service.
- The trust should consider reviewing the process for the nursing handover in the A&E department.
- The trust should consider increasing the amount of information that is available for patients in languages other than English.
- The trust should consider how they can provide better facilities for relatives who need to stay at the hospital because their relative is at the end of life. This should include a suitable space for families and or patients to talk with staff in private on ward 22.
- The trust should consider providing protected time for departmental leaders working in A&E to have time to reflect and plan their service.

# Summary of findings

- The trust should consider ways of improving communications between staff and managers within the A&E department and how this would improve staff morale.
- The trust should consider reviewing the allocation of pharmacy support for the maternity service to provide medicines management and audit support.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

Care Quality Commission

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# Milton Keynes Hospital

## Detailed findings

**Services we looked at**
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

## Contents

# Detailed findings

## Background to Milton Keynes Hospital

Milton Keynes Hospital NHS Foundation Trust consists of one medium-sized district general hospital. Monitor 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 508 hospital beds.

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 local health profile shows that Milton Keynes has two indicators that are worse than the England average: statutory homelessness and violent crime. In 2011, 26.1% of Milton Keynes residents were from an ethnic group, compared with 20% in England as a whole. This included people from the EU.

The trust was rated as band 3 in the July 2014 update of the CQC's Intelligent Monitoring system (the scores range from bands 1-6, with band 1 being the highest risk and 6 the lowest). The highest risks within our monitoring were:

- Sentinel Stroke National Audit Programme (SSNAP) domain 2 – overall team-centred rating score for key stroke unit indicator
- Composite indicator: A&E waiting times more than four hours
- Monitor – governance risk rating
- The number of whistleblowing alerts received.

In 2013/14, the trust had a total income of £168 million and a deficit of £15 million.

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## Our inspection team

Our inspection team was led by:

**Chair:** Helen Coe MBE, Director of Operations at Frimley Health NHS Foundation Trust

**Head of Hospital Inspections:** Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included a CQC inspection manager, 13 CQC inspectors and a variety of specialists, including a professor of respiratory medicine, professor of surgery, consultant in paediatric emergency medicine, consultant obstetrician, clinical director for surgery and critical care, consultant paediatrician (nephrology), junior doctor, senior nurse in medicines and palliative care, lecturer in adult nursing and end of life care, operating theatre manager, A&E nurse, head of midwifery, consultant nurse (critical care) and a paediatric nurse. Our inspection team also included two experts by experience who had personal experience of using, or caring for someone who used, the type of services we were inspecting.

## 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?

# Detailed findings

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

Before our inspection, we reviewed a wide range of information about Milton Keynes Hospital NHS Foundation Trust and asked other organisations to share the information they held. We sought the views of the clinical commissioning group, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, and the local Healthwatch team.

We held a listening event in Milton Keynes on 21 October 2014, where members of the public shared their views and experiences of Milton Keynes Hospital. Some people also shared their experiences of the trust with us by email and telephone.

The announced inspection of Milton Keynes Hospital took place on 22 and 23 October 2014. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually, as requested.

We talked with patients and staff from all the ward areas and outpatients services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection between 5pm and midnight on 2 November 2014 at Milton Keynes Hospital. The purpose of our unannounced inspection was to look at the A&E department and the general management of medical patients out of hours.

We would like to thank all staff, patients, carers and other stakeholders 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

Milton Keynes Hospital NHS Foundation Trust has one location, Milton Keynes Hospital. The trust has 508 beds in total: 398 general and acute, 54 maternity and 24 critical care beds (including 15 neonatal intensive care cots). The hospital employs about 3,000 members of staff. In 2013/14 there were 24,613 admissions, 260,227 outpatients and 78,131 emergency department attendances.

The trust serves a local population of about 252,000 living in and around Milton Keynes.

# Detailed findings

## 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 | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Medical care | Requires improvement | Requires improvement | Good | Requires improvement | Good | Requires improvement |
| Surgery | Good | Good | Good | Good | ☆ Outstanding | Good |
| Critical care | Good | Good | Good | Good | Good | Good |
| Maternity and gynaecology | Good | Good | Good | Good | Good | Good |
| Services for children and young people | Good | Good | Good | Good | Good | Good |
| End of life care | Requires improvement | Good | Good | Good | Good | Good |
| Outpatients and diagnostic imaging | Good | Not rated | Good | Good | Good | Good |
| Overall | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Overall | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |

### Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

# Urgent and emergency services

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

## Information about the service

The urgent and emergency care department at Milton Keynes Hospital comprises an accident and emergency (A&E) department and an observation unit that can care for up to seven patients. In addition, a small dedicated children's A&E department is located in the main body of the department.

The emergency department serves a population of about 300,000 in Milton Keynes and neighbouring counties. This population is projected to increase over the next 10 years.

The A&E department was built in 1984 for an expected attendance of 17,000 patients per year. During the year 2013/14, the department saw 77,183 attendances; this figure is expected to continue to rise as the population of Milton Keynes expands.

Of the attendances 18,645 were children under the age of 16 years. Children have their own waiting and treatment area, able to take four patients at a time.

During our inspection, we spoke to around 50 people, who included patients, relatives and staff.

## Summary of findings

The A&E department required improvement overall, but the effectiveness in the service was good

We found gaps in some records, and there was no auditing to assess how well records were being completed. Medical and nursing staff were not up to date with mandatory training.

The A&E department was divided into an adults' and a paediatric (children's) area. The children's area was not secure, which meant that anyone could enter the area after gaining access to the adult treatment areas.

Staffing levels were sometimes lower than planned, but this was escalated and risk assessed. The trust was recruiting more nurses and consultants.

Generally we found the department appeared clean, but we did find some dust and a dirty floor in the sluice during our unannounced visit.

The trust had consistently failed to maintain the Government's target for 95% of patients to be admitted, transferred or discharged within four hours. Total time spent in A&E was consistently above the English trust average, and ambulance handover times varied.

We found that patients were cared for. However, we saw one incident where the patient's dignity was not maintained. Also, not all patients had their nurse call bell to hand. We saw examples of caring and compassionate interactions with patients.

# Urgent and emergency services

Regular operational, clinical governance and mortality/ morbidity meetings took place; lessons were learned from issues raised. Junior members of staff felt that they could approach their managers. However, there was a lack of communication between departmental leaders and those at a more senior level, which led to frustration. We found an open culture among members of staff, but staff did not always feel that their opinions were listened to and reflected in the planning of future service delivery.

Junior doctors reported that education in the department was of good quality and that they felt supported by registrars and consultants. There were good opportunities for nurses to obtain further training and development. A practice development nurse had recently started in the post.

Service delivery was aimed at people whose first language was English, however patients who were not bale to speak English were identified during the triage process and interpreters were offered if required. The trust provided a language line telephone interpreting service.

A clear process was in place for staff to alert other professionals if a patient's condition deteriorated. We saw staff escalate concerns about a patient's deterioration in a timely way during our visit.

## Are urgent and emergency services safe?

**Requires improvement**

The safety in the A&E department required improvement.

We found gaps in some records, and there was no auditing to assess how well records were being completed. Medical and nursing staff were not up to date with mandatory training; plans were in place to address this, but staffing pressures often prevented staff from attending the training.

There were medical and nursing staff vacancies in A&E. We found that not all shifts had the required number of staff on duty, but this was escalated and risk assessed. The trust was in the process of recruiting more staff, but faced difficulties attracting and retaining staff. The trust was currently recruiting for three consultant vacancies. Locum staff were being used in the interim. At least one consultant was on duty in the department between 8am and 8pm.

The A&E department was divided into an adults' and a paediatric (children's) area. The children's area was not secure, which meant that anyone could enter the area after accessing the adult treatment areas.

Some staff told us that they did not always feel safe in the department, particularly out of hours.

Generally we found the department appeared clean, but we did find some dust and a dirty floor in the sluice during our unannounced visit. Staff did not feel that there were enough cleaners out of hours.

There was sufficient equipment for monitoring and treating patients, for example infusion pumps and cardiac monitors. We found there was no dedicated room to care for patients who were experiencing mental health problems. Medicines were stored safely and securely, including intravenous fluids.

A clear process was in place for staff to alert other professionals of deterioration in a patient's condition, if required. We saw staff escalate concerns about a patient's deterioration in a timely way during our visit.

Staff reported incidents through the incident reporting system. We saw evidence of learning from incidents.

# Urgent and emergency services

## Incidents

- All staff were able to input incidents to the trust's electronic Datix system which is the trusts electronic software for reporting patient safety incidents. Staff we spoke with in A&E and the observations unit stated that they reported incidents and had been encouraged to do so since a new senior member of nursing staff had been in the post. However, two staff members told us they were told not to report incidents because it would make it look like they could not cope. Despite this, we found staff were reporting incidents in the department. Our intelligence did not raise any concerns that the department was reporting a lower number of incidents than would be expected.
- Nine serious incidents had occurred in A&E during 2013/14. Of these nine serious incidents, seven had been closed by the commissioners, one was waiting for review by the commissioners, and one had been approved by the commissioner but had not been closed because the department was still implementing the learning from the incident.
- In response to investigation of falls incidents, the trust had purchased low-level trolleys for elderly patients and those at risk of falls. We saw these in use during our visit.
- A&E produced a newsletter for all staff, which gave feedback on issues raised in the department. We saw a copy of the September 2014 newsletter. It contained six learning points, including about the importance of using pain scores and recording observations. Staff knew about the contents of the newsletter. This meant that the newsletter provided a system to feed learning back to staff.
- Issues and incidents were discussed at a variety of regular meetings within A&E; these included operational meetings, meetings of the clinical improvement group, and mortality/morbidity meetings.
- A senior clinician informed us that rigorous discussions took place during mortality meetings; any lessons learned were shared with the rest of the team.
- Nurse handover meetings, which were held on a daily basis, also included any safety issues that staff needed to be aware of.
- The minutes of the clinical improvement group dated October 2014 revealed that 15 incidents had occurred in A&E and that reports on the Datix system had still to be investigated.

Cleanliness, infection control and hygiene

- We found all areas of the department to be clean and odour free during our announced inspection. Surfaces and mattresses were clean, and we observed cleaning of equipment and trolleys between patients.
- The sluice area on our unannounced visit was untidy and the floor was dirty. Empty cardboard boxes and filled sharps containers were on the floor.We found a thick layer of dust on a shelf over a nurses' station in the 'minors' area. A member of staff informed us they felt there were insufficient cleaning staff available during the evenings and at night.
- Hand-washing facilities, alcohol gel, gloves and plastic aprons were available in all areas we visited. We saw staff using these appropriately.
- A hand hygiene audit for July 2014 in the emergency department revealed failure by two members of staff to wear protective equipment and clean their hands correctly. The department had been compliant for the previous two months. We saw staff washing their hands during our inspection. All trust staff were observed to adhere to the 'bare below the elbows' policy.
- Some of the treatment areas were single bedded with doors for access. We were informed that these areas could be used for isolating patients with an infection, if required; we saw one isolation room being used for this purpose during our visit. After use, the area was deep cleaned by A&E's own staff.
- If a patient with a known methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile infection attended A&E, all staff were notified and precautions were taken.
- Policies and procedures were in place for any patient suspected of having infectious diseases. Decontamination equipment was available; staff had received training and felt confident on its use.
- Privacy curtains in A&E and the observations unit were disposable. Staff were uncertain how often the curtains were changed, so we asked for clarification. We were informed that the curtains were changed every six months unless they needed to be changed earlier. Dates for changing the curtains were visible on some of the curtains but not on others. For example, two sets of curtains in the observation ward had no visible change date on them.

# Urgent and emergency services

### Environment and equipment

- A&E could care for up to 27 adults in three different areas of the department. Plans were already advanced to reconfigure the treatment area in order to increase the adult area by four trolley spaces for treating minor injuries.
- The children's area could treat up to six children at a time. The separate paediatric (children's) waiting area was well appointed, spacious and bright, with an adequate seating area, a television and toys available to allow free play.
- No quiet room was available for assessing patients presenting with a mental health problem.
- There was sufficient equipment for monitoring and treating patients, for example infusion pumps and cardiac monitors.
- A new cardiac monitoring system was about to be installed in A&E. We were informed that the clinical staff who used the equipment had not been able to choose the type and model to be purchased.
- Although we did not see any bariatric equipment in use, staff informed us that bariatric equipment was available when required, including wheelchairs and trolleys.
- Equipment we examined had been serviced and was in working order.
- Resuscitation equipment in all areas was appropriate.
- The observation unit situated next to A&E had no windows, and therefore patients did not have access to daylight. Some patients had needed to spend longer than overnight in the observation unit because of a lack of beds elsewhere in the hospital.
- We spoke to staff in the observation unit, who informed us that if they needed a hoist to help them move patients they had to borrow one from a neighbouring ward.

### Medicines

- The A&E department had a designated nurse in place who was responsible for ordering medicines and liaising with the pharmacy.
- Medicines requiring cool storage were stored appropriately, and records showed they were kept at the correct temperature and so would be fit for use.
- We saw that controlled drugs were stored and managed appropriately.
- Emergency medicines were available for use, and there was evidence that they were regularly checked.
- A quiet area was available for preparing intravenous drugs.
- Information from the trust showed there had been a total of 45 medication errors in the emergency medicine department between September 2013 and August 2014. The majority of errors resulted in no harm or minor harm to patients.
- Prescription forms for issue to patients to obtain medicines outside the hospital were stored securely. The arrangements for recording the serial numbers of these forms could have been further developed, however, to ensure prompt identification if any were used fraudulently to obtain medicines.
- We had received information before our inspection relating to the lack of medicines for a patient in the observation unit. We spoke with staff on the unit, who informed us that medicines could always be accessed out of hours if required.

### Records

- Records on the observation unit were kept in a lockable cabinet and only accessible to healthcare professionals. A&E records for patients who had been referred to a specialty were kept in an open trolley, but staff were always in the area.
- All records were in paper format. In A&E we saw that initial triage and assessment of both children and adult patients was recorded on two individual pieces of paper placed in a folder.
- A medical model was used recording: initial triage; observations, for example temperature and blood pressure; presenting condition; and past medical history.
- Original paper records did not leave A&E. Processes were in place for photocopying the records when patients were admitted to wards, or scanning and uploading them onto an electronic system before they were destroyed. Any further information required, for example about individual risk assessments, was added to the file.
- An adult admission booklet was available. We saw this in use on A&E and the observation ward. It included a patient summary, activities of daily living, and assessment of pressure ulcers and falls risk.

- A member of staff informed us that the system had been the same for the past 18 years. One member of staff felt that the whole system needed updating because it was not fit for purpose. Another staff member told us that sometimes pages went missing.
- The malnutrition screening tool (MUST) and falls and pressure ulcer assessment tools were completed for the two patients' notes in the observation unit.
- A document for discharges from A&E was being piloted and included items relating to vulnerable adults, removal of intravenous cannulas and medication.
- Auditing of records was not being undertaken at the time of our visit.

**Safeguarding**

- Staff we spoke with in all areas were aware of the trust's safeguarding procedures for adults and children, and of what constituted abuse and how to report it.
- Nurses in children's A&E knew how to raise concerns with senior colleagues and doctors about possible non-accidental injuries to children. Policies and procedures were in place to protect such children.
- All staff in A&E had received level 2 safeguarding training as part of their mandatory training. Senior nursing staff and doctors had received level 3 safeguarding training. This meant the senior decision makers within A&E had received additional training and were aware of the processes to follow if they had concerns about a patient.
- Additional documentation was available for children attending A&E to record any safeguarding or child protection issues in order to alert the appropriate agencies.
- Children were routinely admitted as inpatients if they were deemed to be at risk, for example, of non-accidental injury.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we spoke with told us they were asked for their verbal consent before procedures were undertaken.
- Written consent was obtained from patients who required procedures under an anaesthetic before the procedures were undertaken.
- Documentation used to support or assist healthcare professionals in assessing capacity was available electronically on the trust's intranet system using an assessment of 20 questions.
- Staff we spoke with were aware of the Mental Capacity Act and were able to demonstrate an understanding of this. The subject was part of staff mandatory training.

## Mandatory training

- Mandatory annual training included basic life support, infection control, fire training and safeguarding children level 3. Other elements were undertaken on a two- or three-year basis.
- Information received from the trust showed the current status for completed mandatory training for all levels of staff was; Medical staff: 67%, Nursing staff: 76%, Reception staff 93%, Managers 71%.
- The trust's target for mandatory completion of training was 80% for all staff. Senior members of staff in the emergency department had acknowledged that mandatory training levels required improvement and were working towards this.

## Management of deteriorating patients

- Patients walking into the A&E department were booked in by a receptionist and directed to the waiting room before being triaged by an experienced nurse. The triage room was situated off the main waiting area.
- We were informed that each patient was given a RAG rating (red, amber, green) depending on the urgency of treatment; this was evidenced on the triage sheet for each patient. We found that not every patient's RAG rating was documented.
- A triage system was in use and notes were placed in order by the nursing staff. They were adjusted as necessary to ensure patients were seen in priority order. Patients who were attending with cardiac like chest pain had their notes placed in a separate triage box at the reception desk so the triage nurse was altered immediately.
- The reception staff had good sight of all patients. They informed us they would raise the alarm if a patient showed any sign of deterioration and alert nursing staff.
- The use of care bundles or pathways for adult patients with specific illnesses was good. Care bundles were in place, for example for patients who had suffered a stroke or patients with sepsis or a head injury.
- No distinct pathways were in use in children's A&E; this had been placed on the risk register for the department in March 2014. We found that paediatric guidelines were on the trust's intranet, but there were no specific care pathways, for example for asthma, sepsis and head injury.

- For children with chronic illnesses who attended A&E rather than the paediatric ward with an acute exacerbation of their disease there was a process in place to fast-track the child to the children's ward. Children with a chronic illness are placed on a scheme known as the "Red Box," which means they have open access to the paediatric team.
- A protocol was in place for patients suffering major haemorrhage.
- If an on-going assessment of the patient's observations was required, it was recorded using the hospital's early warning system observation chart based on the national early warning score (NEWS) tool. For children, the Paediatric Early Warning Score (PEWS) was used. The scores are a simple, physiological score whose primary purpose is to prevent delay in intervention or transfer of critically ill patients. A clear process was in place for staff to alert other professionals of a patient's deterioration, if required.
- We saw staff escalate concerns about a patient's deterioration in a timely way during our visit.
- A rapid triage consultant was allocated during the day time for two designated trolley bays within the department. There was also an additional consultant and more space could be made available to support the rapid triage where necessary. Once the bays were full the process slowed considerably and became less effective.

## Nursing staffing

- The department ran an internal rotation system, with nursing staff working both days and nights.
- The planned staffing levels for the department were; ten Registered Nurses on the day shifts and nine on the night shift, plus three healthcare assistants on both the day and night shifts. In addition, the Matron and Clinical Operational Manager were supernumery and there were at least two Emergency Nurse Practitioners on each shift. A registered children's nurse and healthcare support worker were also provided to cover the children's department.
- The nursing establishment in the emergency department was 79 whole time equivalent (WTE) nurses. There were 4.86 WTE band 5 nurse vacancies, a 0.76 WTE band six vacancy and 0.72 WTE band seven vacancy. Bank and agency nurses covered the vacancies, but the trust were actively recruiting for new nursing staff.
- Examination of the nurse staffing rotas showed that bank and agency nurses were used on a regular basis. The same bank and agency nurses were used, where possible, to support A&E to provide continuity for staffing shortfalls.
- We saw some examples within the department where nurse staffing levels were not in line with the required numbers. When they were different we saw staff followed an escalation procedure and the situation was risk assessed. During our visits to the department we did not see evidence that patients' needs were not being met as a result of nurse staffing levels.
- Senior staff informed us that two qualified nurses should always be in the resuscitation area, but staff told us this rarely happened. Staff were concerned about this and the impact it had both on them and their patients.
- Nursing staff reviews using a recognised staffing tool for emergency departments had not been undertaken during the past two years.
- Some junior staff were not aware whether the trust was going to raise staffing levels in the department to respond to the increasing demand. However the trust informed us that a business case had been approved and recruitment had already begun. The trust told us this had been communicated to staff.
- Handovers between different nursing shifts occurred twice a day. We were present for two handovers during our announced and unannounced visits to A&E. Because of its location, the room for handover was in constant use by doctors and ambulance personnel. This led to a very disrupted process, with interruptions and telephones ringing. Staff acknowledged that the location of the room was not ideal for handovers.
- The children in A&E were not included in the handover unless they were very sick. A separate process took place in children's A&E between outgoing and incoming staff.

## Medical staffing

- The Royal College of Emergency Medicine recommends 10 specialist consultants for an A&E department that sees between 50,000 and 80,000 patients per year. This is a recommendation and not a national minimum standard. The A&E department had the equivalent of

seven whole-time consultants. Locum consultants were also employed and the trust had increased the numbers of middle grade doctors. In addition the trust has employed five additional emergency physicians to provide consultant support to assist with the assessment of emergency patients for possible admission."

- The trust had given approval for recruiting up to three more consultants, and the posts were advertised.
- At least one consultant was on duty in the department between 8am and 8pm. A consultant was frequently in the department beyond those hours; we spoke with one at midnight on our unannounced visit, who was just leaving the department. Outside the eight core hours, a consultant was on call within half an hour's drive of the hospital.
- All the doctors we spoke with of all grades felt there was sufficient medical cover in the department to give a good service to patients.
- At the time of our visit, no consultant with a paediatric (children's) subspecialty was available in the department. One of the A&E consultants had a special interest in paediatrics, and a junior paediatric doctor was available on the children's ward, when required, alerted by a 'bleep'; staff stated that response times were variable.
- Ten middle-grade doctors were required to cover a 24-hour period in the department. This comprised staff-grade and training-grade doctors, with the use of locums on a regular basis.
- We spoke with a locum middle-grade doctor who had received a half-hour induction to the department at the beginning of their first shift, including an introduction to colleagues and guidance on the trust's computer systems; they felt this was adequate. The trust did not supply us with details of locum induction processes.
- Handovers between medical staff occurred at different times of the day, depending on doctors' length of shifts.

### Major incident awareness and training

- A major incident policy was in place for use by the department, but no signage was displayed in A&E about it.
- Equipment required for a major incident had been moved immediately before our inspection. This had led to some confusion about its whereabouts.
- It was unclear where the keys were for accessing the major incident equipment; they were eventually found.
- Equipment was located in cages, but was stored in a disorganised way. We were informed that the equipment was due to be rearranged on the day of our visit.
- Action cards for use during a major incident were available, detailing the roles for all trust personnel.
- A tent was available for erection outside A&E, so that any patients contaminated by chemical, nuclear or biological agents could be treated appropriately.
- A 'winter pressures' plan was in place.

### Patient and staff safety

- Staff we spoke with stated they generally felt safe when working in A&E, but at times they were concerned at the lack of security staff. Two members of staff told us they felt unsafe at times, especially during the night.
- The A&E department was divided into an adults' and a paediatric (children's) area. Children needed to walk through the adult area to gain access to the children's waiting and treatment areas. The children's area was not secure, which meant that anyone could enter after gaining access to the adult treatment areas.
- During evenings and weekends, one member of security staff was on duty for the whole hospital. Portering staff were used for security issues if necessary.
- On arrival in A&E during our unannounced visit, we found the door from the waiting room to the main treatment areas was wide open. A notice stated that the doors should be closed at all times. We questioned a member of staff, who told us the doors should always be shut, but when patients or relatives accessed the waiting room from the department the doors stayed open. Doors were also open from the main corridor of the hospital into A&E. This meant the department was not secure.
- A business case had been put forward to have additional security presence in A&E. We were informed that a police officer was based in A&E, although not always present in the department. Panic alarms were available to summon assistance in both the reception and triage areas and staff had been trained in conflict resolution but not in restraint.

## Are urgent and emergency services effective?

(for example, treatment is effective)

# Urgent and emergency services

Good

We judged that the effectiveness of the service was good.

Unplanned re-attendance rates to A&E within seven days were better than the England average. The department followed national guidance. Pain relief was given in a timely manner although no nurse-led analgesia was in place which could delay time for patients getting adequate pain relief. Nutrition and hydration were offered to patients when appropriate.

Junior doctors reported that education in the department was of good quality and that they felt supported by registrars and consultants. Appraisal rates for staff were below the trust's target, but doctors felt supported to access training and education.

Good opportunities were available for nurses to obtain further training and development. A practice development nurse had recently started in the post.

Staff we spoke with were aware of the Mental Capacity Act and were able to demonstrate an understanding of it.

### Evidence-based care and treatment

- The trust had agreements in place with South Central Ambulance Service NHS Foundation Trust to ensure that patients were transported to the correct healthcare provider, depending on their illness. For example, major trauma patients were taken to the John Radcliffe Hospital in Oxford, and patients experiencing a hyper-acute stroke were taken to the Luton and Dunstable Hospital. (Hyper-acute stroke patients are those presenting within six hours of the onset of a stroke.)
- The department worked in accordance with national guidance. Protocols were available for some common diseases, using National Institute for Health and Care Excellence (NICE) guidance. The protocols were based on the best available evidence. We saw the protocols for the management of strokes, sepsis and major blood loss.
- We asked two doctors about their use of the clinical standards for emergency departments produced by the Quality in Emergency Care Committee of the College of Emergency Medicine (CEM). The standards are developed by consensus among emergency physicians with relevant expertise, and with input from other relevant stakeholders. The two doctors told us they used the guidance from CEM.

### Pain relief

- We were informed that an assessment of pain was undertaken on a patient's arrival in the hospital, as part of the admission process. However, our observation of care records indicated that if a pain assessment occurred, it was not always documented; the same applied for children.
- We saw there was minimal re-evaluation of pain once patients had been administered analgesia.
- We saw one patient who was experiencing a great deal of pain while in the waiting room. We alerted staff, who took prompt action.
- No nurse-led analgesia was in place in A&E, and patient group directives (PGDs) were not in use. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presenting for treatment. In an A&E department, simple analgesia such as Paracetamol could be administered by nurses before being prescribed by a doctor.)
- All medication needed to be prescribed by doctors before administration. This meant that patients might be waiting for analgesia for a long time, although we did not see this occur during our inspection.

### Nutrition and hydration

- Patients in the A&E department for any length of time were offered something to eat and drink when this was appropriate and safe to do so. Hot meals were available at lunchtime. On other occasions, sandwiches were offered.
- Those patients in A&E who had needed to stay in the department overnight were served breakfast. The department had a full time housekeeper. In addition there were volunteers in the department whose role is was to ensure patients had access to food and drink.
- On the observation ward, patients were offered food and fluids. They had access to the same meal service as patients on the inpatient wards.
- We observed patients being offered fluids. Patients we spoke with had mugs of tea or coffee on tables when they were permitted to have them.

# Urgent and emergency services

### Patient outcomes

- Unplanned re-attendance rates to A&E within seven days ranged from 6.3% in January 2013 to 7.2% in February 2014; this figure was better than the England average.
- The trust had a protocol to ensure that patients with fractured hips had quick access to an orthopaedic ward. We noted that the percentage of fractured neck of femur patients seen and operated on within 48 hours was above the England average, at 90.2%.

### Competent staff

- Patients we spoke with felt very confident about the staff's ability to care for them appropriately.
- Staff were aware of the trust's guidance for particular illnesses, for example strokes and chest pain.
- All the nursing staff we spoke with felt competent to undertake their role. Nursing staff were trained in basic life support and received regular updates.
- Not all staff had received appraisals. Data received showed that in October 2014, 66% of nursing staff in the emergency department had received appraisals. Plans were in place to improve this.
- Junior medical staff we spoke with told us they had opportunities to attend regular training sessions. In a report from Health Education Thames Valley from March 2014, junior doctors reported that education in the department was of a good quality and that they felt supported by registrars and consultants.
- Revalidation for medical staff was on schedule.
- Opportunities were available for nurses to develop: four nurses had completed a trauma course during 2014; one nurse was undertaking the non-medical prescribing course, and a further three nurses were due to start this in February 2015; three nurses were undertaking the emergency nurse practitioner course; 10 nurses had started training to become x-ray requesters; three nurses were nominated to complete a high dependency course in paediatrics; two nurses were completing an external leadership programme; one nurse was undertaking a degree, with trust funding.
- There was regular weekly teaching in the department to support informal teaching of clinical/quality issues. The department had recently appointed a practice development nurse to work four days per week.
- The trust had commissioned a bespoke emergency department course, which had received accreditation from Bedfordshire University. There were 15 places for the department.

### Multidisciplinary working

- We witnessed excellent interaction between doctors and nurses during the inspection.
- Staff in the department told us that internal multidisciplinary working, for example between specialties, was generally good. However, some staff felt this could be more effective, to improve the flow of patients out of the department, especially those requiring a medical bed. The trust was working towards a better model to improve care for medical patients.
- A rapid assessment intervention team (RAIT) was available between 8am and 9pm, Monday to Friday, to assess older people in A&E and determine whether they were safe to return home when discharged. Staff thought the assessments worked well.
- Nursing staff reported that patients requiring referral to psychiatric services when the department's psychiatric nurse was not on duty were generally seen promptly by the specialist liaison team. Any delay put additional pressure on staff who did not have the relevant experience.
- The trust employed a full time dedicated drug and alcohol specialist nurse who supported patients with alcohol or drug dependency. In addition, staff accessed a voluntary agency for supporting patients with an alcohol dependency
- There was a rapid pathway for women presenting at A&E with blood loss during early pregnancy.
- Plans were in place to relocate the urgent care centre closer to A&E and ensure that the two areas worked more closely together in the future by improving patient pathways.

### Seven-day services

- A&E and the observation ward were open 24 hours a day, seven days a week, with access to support services, for example x-ray, scanning and haematology.

## Are urgent and emergency services caring?

# Urgent and emergency services

Requires improvement

We saw one incident where the patient's dignity was not maintained. Also, not all patients had their nurse call bell to hand.

Milton Keynes Hospital NHS Foundation Trust was one of 10 trusts that were classed as 'worse than expected' for at least 20% of all scored questions in the 2014 A&E patient survey.

Patients felt they were listened to by health professionals and were involved in their treatment and care. We saw examples of caring and compassionate interactions with patients. Facilities were available to support relatives in distress.

Patients who walked into the A&E department experienced a lack of privacy while giving confidential information to staff, because of the reception arrangements.

## Compassionate care

- We saw that curtains were not pulled around patients in all areas of A&E. When we spoke with patients, they informed us they had been asked, but it was their choice to have the curtains open.
- We observed a member of staff helping an elderly patient onto a commode without pulling the curtains fully around the patient. Another member of staff administered an intravenous injection without pulling the curtains. This meant the patient's privacy and dignity were compromised.
- The 2013 patient survey score was about the same as for other trusts for questions relating to being given enough privacy when being examined or treated in the A&E department.
- All the cubicle areas in A&E except one were fitted with nurse alarm calls. During our unannounced visit, we saw only one patient who could reach the alarm call. We asked a nurse about this and were told that every patient should have been given an alarm call.
- All the patients we spoke to in all the areas we visited were complimentary about the care they had received, and had felt respected. One patient told us, "They're rushed off their feet but they still have time to smile. I don't know how they do it."
- We saw examples of caring and compassionate interactions with patients given in a quiet and dignified manner in both the areas we visited.
- When patients gave details to receptionists in the waiting area, other people could overhear confidential information. The trust had acknowledged this issue, and we were informed that plans were in place to improve in the area.
- Milton Keynes Hospital NHS Foundation Trust was one of 10 trusts that were classed as 'worse than expected' for at least 20% of all scored questions in the survey. 29% of the questions asked of patients scored worse than the majority for other trusts.

## Patient understanding and involvement

- Staff introduced themselves to patients by name.
- Patients we spoke with told us they understood what staff said to them and felt informed about care and treatment options.
- We saw relatives in all areas of A&E. They told us they had been able to sit with their loved ones while they were in A&E, which they had appreciated.
- We did not see any relatives on the observation unit to talk with.

## Emotional support

- A relatives' room was available in a quieter area of A&E. This was available as a room in which to break bad news or for bereaved relatives to sit in. Refreshments were available if required.
- We spoke with a patient who was waiting for the results of tests. The patient was very anxious; staff were very busy at the time, and it appeared no-one had noticed. We spoke with a consultant, who discussed the results with the patient.
- We spoke with another patient who used the A&E service frequently. The patient had concerns about their on-going care. We saw staff support the patient when they became distressed.
- A nurse specialising in supporting patients with a mental health problem was present in A&E on our unannounced visit.
- Spiritual support was available for those who required it, from local leaders of different faiths, for example Christians and Muslims.
- The staff in the department had close contact with the trust's bereavement team. The bereavement team followed up with every family who had experienced loss.

# Urgent and emergency services

**Are urgent and emergency services responsive to people's needs?**
(for example, to feedback?)

**Requires improvement**

The trust had consistently failed to maintain the Government's target for 95% of patients to be admitted, transferred or discharged within four hours. Total time spent in A&E was consistently above the English trust average, and ambulance handover times varied. The percentage of patients waiting for four to 12 hours from a decision to admit them to actual admission was generally higher than the English trust average over the previous 12 months.

Service delivery was aimed at people whose first language was English, however patients who were not able to speak English were identified during the triage process and interpreters were offered if required. The trust provided a language line telephone interpreting service.

Lessons learned from complaints were relayed to staff in the newsletter to prevent reoccurrence.

### Service planning and delivery to meet the needs of local people

- The trust had acknowledged that lack of space in A&E was a concern. There had been recent investment in creating additional capacity in the unit, which had just opened at the time of our inspection.
- The trust and the commissioners had recognised that the department was in need of further development in order to meet the increasing demands being placed on it.
- The trust had commissioned a strategic outline case to redevelop the whole department. The aim was to fully incorporate a primary-care-led urgent care centre that was part of the strategic direction approved by local commissioners.
- Two vending machines were in the waiting room, one for drinks and the other for snacks.
- We saw no signs in languages other than English. We noted that about 20% of the population in Milton Keynes are from ethnic minority groups.

### Access and flow

- An electronic system was in place for tracking how long patients had been in the department, to ensure they were treated in a timely way.
- The trust had consistently failed to maintain the Government's target for 95% of patients to be admitted, transferred or discharged within four hours part from 4 weeks out of 17 weeks. Between January 2014 and April 2014, the rate dropped to 45%. Data for September 2014 showed an improvement: 97% of patients were admitted, transferred or discharged within four hours.
- The time that patients spent in A&E was consistently higher (i.e. worse) than the English trust average, varying from 135 minutes in August 2013 to 180 minutes in March 2014.
- Ambulance waiting times – the time that ambulance personnel wait to hand over patients to A&E staff and prepare to leave – had fluctuated between April and August 2014. In July 2014, 118 ambulances waited over 30 minutes and 35 waited over an hour. In June 2014, the number was lower, with 77 waiting over 30 minutes and 14 over an hour.
- The percentage of patients waiting for four to 12 hours from a decision to admit them to actual admission was generally higher than the English trust average over the previous 12 months. In August 2013, the percentage was 1%. By August 2014 this had risen to 23%.
- The percentage of patients leaving A&E without being seen was higher (i.e. worse) than the English average, varying from 5.5% in February 2013 to 3% in January 2014.
- During both days of the planned inspection and on the evening of the unannounced inspection, the A&E department was very busy; staff informed us this was usual. The observation unit was full on all occasions.
- During our unannounced inspection, only one of the seven beds in the observation unit was being used to observe an A&E patient; the remaining six patients were awaiting medical beds in the main hospital. These medical patients waiting for admission were therefore required to stay overnight in A&E, which reduced the ability of staff to see A&E patients in a timely manner. The trust had highlighted this issue on its risk register in September 2014 and stated that the controls for the risk were inadequate. The trend was increasing.
- Patients in A&E who had been identified as needing to sleep in the department because, for example, of a lack

of beds in the observation unit or on the wards, were placed in beds overnight. There was a great deal of noise in A&E and lights were bright, so patients' sleep was limited.

### Meeting people's individual needs

- Patients we spoke with felt they were treated as individuals in their own right.
- Service delivery was aimed at people whose first language is English, however interpreters were provided to patients as required. Any patients who may have required an interpreter were identified during the triage process. We observed a person translating for a relative during our visit; the relative had given permission for this.
- We also observed a member of staff caring for a patient who was living with dementia. The interaction was good and the member of staff was able to calm the patient.
- The trust told us there was a named dementia champion for the emergency department. On display in the department was a dementia education board collated by the champion, with information on assessment and diagnosis as well as the trusts dementia care process.
- The trust had put a programme of dementia training in place for healthcare support workers. Qualified staff had not received the training.
- The trust did not employ a specialist liaison nurse in A&E to support patients with alcohol or drug dependency but could refer patients to a drug and alcohol service that was provided by another organisation.
- Information was available for people who had been involved in domestic violence.
- Specially trained nurses to care for patients with a learning disability were available from the Central North West London Community Health Trust when required.
- The waiting area in A&E was equipped with chairs for patients. Patients could also sit on chairs in corridors in the minor injuries area when treatment areas were full.

### Learning from complaints and concerns

- The trust had a complaints, concerns, compliments and comments policy in place, dated March 2014.
- There had been 22 complaints rated as 'moderate' or 'complex', and 43 informal complaints, 11 verbal complaints and 104 compliments. Trends in complaints were analysed and reported through the governance structure.
- Complaints and serious incidents, with any lessons learned from them, were discussed at clinical governance meetings in the department. Information for staff was relayed using the department's newsletter. For example, staff were reminded of the importance of examining the hip joint when a patient presented with knee pain.
- Lessons learned from complaints were relayed to staff in the newsletter to prevent reoccurrence.
- Information leaflets and posters about how to make a complaint were available in the department.

## Are urgent and emergency services well-led?

**Requires improvement**

We found the that clinical leadership of the department required improvement.

Staff were aware of the quality care element of the hospital's strategy, but not the three contributing elements. Staff felt that the trust was more focused on targets than on patient care. Some staff thought that they would raise issues about safety concerns or poor practice in their department; others thought that they would not. Regular operational, clinical governance and mortality/morbidity meetings took place; lessons were learned from issues raised.

Junior members of staff felt they could approach their managers. However, there was poor communication between departmental leaders and those at a more senior level, which led to frustration. We found an open culture among members of staff, but staff did not always feel that their opinions were listened to and reflected in the planning of future service delivery.

# Urgent and emergency services

## Vision and strategy for this service

- The hospital's strategy encompassed three elements – service delivery, education and training, and research and development – leading to high quality care for patients.
- Staff were aware of the quality care element of the hospital's strategy, but not of the three contributing elements.
- Although staff focused on achieving national targets and realised the importance of them, all staff we spoke with felt that, in the current climate, it was impossible achieve the targets. Staff thought this was impossible mainly because of the size of the department, shortage of nursing staff and slow exit of patients to other areas of the hospital.
- A doctor informed us, "We could give an excellent service, but the slow flow of patients impedes that."
- Since September 2014, there had been a £0.75 million refurbishment in the immediate assessment environment, and a further £2.8 million was being invested in a new assessment area being built next to the current unit. It was hoped the new acute medical unit would improve the flow of patients through the hospital and release pressure on the A&E department.
- The trust had commissioned a strategic outline case to redevelop the whole department to fully incorporate a primary-care-led urgent care centre as part of the strategic direction that had been approved by local commissioners.

## Governance, risk management and quality measurement

- We asked staff whether and how they would raise issues about safety concerns or poor practice in their department. Responses varied. Most staff told us they felt confident taking any concerns to their line manager and knew that their concerns would be dealt with promptly. Others told us they did not think they would be listened to.
- Structured emergency department meetings were in place. These included regular operational meetings, clinical governance meetings and mortality/morbidity meetings.

## Leadership of service

- A good rapport existed between all levels of clinical staff. We saw this during our visit.
- Staff felt that rapport had improved in the previous four months.
- We spoke with a range of staff in the department. Staff were knowledgeable about the services they delivered and proud to work in the department. They all stated that local leadership had improved over recent months and that they felt supported.
- Although the departmental leaders of the service worked together regularly, there was a lack of uninterrupted and dedicated time for them to meet and discuss the future strategic direction of the service. This meant there was a reactive way of working with insufficient time to plan for the future.
- Junior members of staff felt they could approach their managers. However, we found a disconnect because of poor communication between departmental leaders and those at a more senior level.
- Staff at all levels informed us they felt that trust leadership was concerned with departmental targets and not outcomes for patients.
- We spoke with the trust's executive and non-executive leadership team. They consistently told us that targets were not the main focus and that patient outcomes were the priority. We found no evidence that the executive team was driven by targets rather than patient outcomes. The staff's perception of the focus of the leadership teams therefore did not match what the teams told us.

## Culture within the service

- Morale among nurses varied. While it was generally thought that morale had improved over the previous four months, staff felt stressed about the pressure of the workload.
- Members of staff informed us that the department had lost a number of good nursing staff during the previous 12 months for different reasons. One reason was that staff risked losing their registration if anything went wrong.
- Staff we spoke with told us they felt supported by their immediate line managers, who had open-door policies and, when available, were approachable. Staff informed us there was an open culture among members of staff who worked together. We saw staff sharing concerns with each other regarding patient care.

## Public and staff engagement

- Opinions differed when staff were asked whether their opinions were listened to and reflected in the planning of future service delivery. Some staff felt more positive about this than others.

# Urgent and emergency services

- The department had joined the hospitals children's service with the 'tops and pants' initiative, which was designed for children to give the team feedback on their care. Children tell the department what was good ('tops') about their care and what was less good ('pants').
- The trust had commissioned and taken part in the emergency department's 'picker' survey to gain a deeper understanding of patients' feedback, on top of the Friends and Family test.

### Innovation, improvement and sustainability

- New software was being introduced in December 2014 to ensure that accurate and appropriate decisions were made about getting patients to the most appropriate beds for them in a timely fashion.
- A system-wide review of the flow of emergency patients, including discharges, was due to be undertaken to assess and validate progress in the department. The work would lead to refocused commissioning arrangements for the rapid assessment and intervention team (RAIT). It would also clarify the role of intermediate care and the other services, including the third sector, used to assist A&E in safe discharges home.

# Medical care (including older people's care)

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

## Information about the service

Milton Keynes Hospital NHS Foundation Trust provides medical care at Milton Keynes Hospital. There are 10 medical inpatient wards, including two wards designated as medical assessment units. The medical division includes a number of different specialties such as general medicine, cardiology, respiratory medicine, haematology and stroke care.

We visited all 10 inpatient wards plus the Macmillan Cancer Unit, endoscopy clinic, day ward and patient discharge unit. We spoke with 80 patients or their relatives/carers. We also spoke with a range of staff including doctors, nurses, healthcare assistants, therapists, administration staff, porters and managers. We observed how care and treatment was provided and we looked at the records of 60 patients. Before the inspection, we reviewed performance information from and about the trust.

## Summary of findings

Overall, we rated medical care as requiring improvement. The medical division required improvement across the 'safe', 'effective' and 'responsive' domains. The 'caring' and 'well-led' domains were good.

The uptake of staff mandatory training in the medical division had not met the trust's target. Only two inpatient medical wards had achieved the target of 85% of staff having undertaken the training.The standard and consistency of records varied widely. Although issues with records had been identified, effective action had not been taken to address this.

Nursing staff levels were not always maintained as planned. Staff told us that staff shortages were common. Patients and visitors told us that staff were frequently very busy, which sometimes led to delays in providing care and treatment. The trust was actively recruiting nurses to fill vacancies.

Effective systems were in place for reporting incidents. Standard operating procedures, systems and processes promoted safe care, were reliable and met relevant guidelines.

The care and treatment of patients generally followed evidence-based best practice and professional standards. Most patients we spoke with were positive about the care they received from staff. Patients felt their dignity and privacy were respected and described staff as kind and caring.

# Medical care (including older people's care)

There were significant problems with the flow of patients from the emergency department to the medical assessment unit and other wards, and the hospital bed occupancy rate was consistently high. This meant that patients often experienced long delays in being moved from the medical assessment unit to other wards.

Suitable arrangements were in place for governance and risk management. There was a strong patient partnership group for cancer services which had brought about improved experiences for patients.

## Are medical care services safe?

**Requires improvement**

We judged that the safety of medical services required improvement.

The standard and consistency of records varied widely. Some records were well completed, but many lacked important details. Although issues with records had been identified, effective action had not been taken to address this.

The uptake of staff mandatory training in the medical division had not met the trust's target. Only two inpatient medical wards had achieved the target of 85% of staff having undertaken the training.

Individual patient risks were generally assessed and monitored, and staff recognised and responded appropriately to changing levels of risk.

Nursing staff levels were not always maintained as planned. Staff told us that staffing shortages were common. Although agency staff were used to provide cover, this could cause problems with staff skill mix, and agency nurses were sometimes unfamiliar with the ward routines and documentation. Patients and visitors told us that staff were frequently very busy, which sometimes led to delays in providing care and treatment. Medical staffing was generally sufficient during the day, from Monday to Friday, but staff were more stretched out of hours. Nursing staff reported long waits for doctors to attend the wards out of hours. We saw that this had an impact on patient care at times, because patients were left waiting for medication and intravenous fluids.

Effective systems were in place for reporting incidents, including allegations of abuse. Any member of staff could report an incident. Staff knew how to report incidents. Staff usually received feedback from incidents, including lessons learned and action to be taken.

Standard operating procedures, systems and processes promoted safe care, were reliable and met relevant guidelines with regard to: infection prevention and control; layout, cleanliness and maintenance of facilities; use and maintenance of equipment; and the management of medicines.

# Medical care (including older people's care)

## Incidents

- The number of incidents reported in the medical division had risen overall between September 2013 and September2014. (In September 2013, 119 incidents were reported; in September 2014, 163 were reported.) The trust viewed this increase as a positive response to staff being encouraged to report incidents.
- However, the trust acknowledged that the number of incidents reported had an impact on the investigation of incidents. The trust had recognised the risk of overdue investigation of incidents and had taken steps to address this. The number of incidents overdue for review had risen to 217 in June 2014, falling to 161 in August 2014.
- Patient falls were the most reported incident in the medical division. Statements of concern where no incident occurred were the second most reported; these mostly related to staffing levels or to staff skill mix on the wards.
- Staff knew how to report incidents and gave examples of what they would report, such as accidents to patients, staff shortages and allegations of abuse. Staff told us that any member of staff could report incidents.
- Staff told us they usually received feedback from incidents they reported. They said they were made aware of learning from incidents, and gave examples of changes and improvements made. One example was an incident where a patient had an unexpected reaction to a platelet infusion. Following this, changes were made to the checks carried out before platelet infusions were given.
- There were monthly mortality and morbidity meetings held by the Cardiology team. In addition a divisional monthly mortality and morbidity meeting was open for all staff to attend from the medicine division. These meetings were used to learn from patient deaths and other incidents. Mortality and morbidity meetings for the rest of the medical division were not held regularly.

## Safety thermometer

- We saw that information about the number of inpatient falls and hospital-acquired pressure ulcers was displayed in each ward we visited. Although the information was available, the way in which it was presented could have been difficult for patients and visitors to understand.
- Other information gathered for the Safety Thermometer about hospital-acquired infections, including urinary tract infections, was not displayed in the wards we visited.

## Cleanliness, infection control and hygiene

- We found that medical wards were clean and well maintained. Single rooms were available for those patients who required treatment in isolation to prevent cross infection.
- Equipment was appropriately checked, cleaned and maintained in the areas we visited.
- The trust had a 'bare below the elbows' policy. ('Bare below the elbows' is an initiative aiming to improve the effectiveness of hand hygiene practices performed by healthcare workers.) We saw that staff adhered to this policy. We saw no staff wearing inappropriate jewellery.
- Personal protective equipment such as disposable gloves and aprons, and alcohol hand gels were available throughout the wards. We observed staff washing their hands before and after providing care to patients and using hand gels appropriately. Visitors were prompted to use hand gels by notices on display around the hospital and the availability of hand gel dispensers.
- Hand hygiene audits were carried out monthly for all wards and areas in the medical division. The hand hygiene audits for July 2014 showed a high level of compliance for all inpatient wards in the medical division.
- The trust had 3 cases of methicillin-resistant Staphylococcus aureus (MRSA) in 2013/14. There had been no cases of MRSA in 2014/15 up to the time of our inspection.
- The trust data for Clostridium difficile (C. difficile) infection showed an upward trend, and figures were above the England average for almost a year. The trust's figures for Methicillin-sensitive Staphylococcus aureus (MSSA) were varied, although there appeared to be a trend that numbers were increasing. No specific information was available to inform patients and visitors about the rates of infection on each ward.
- There was a daily 'huddle' meeting at 10am attended by ward sisters or matrons from each ward and representatives from other teams such as the estates department. This meeting was to share updates and

current concerns from all areas, including infection control issues, and to discuss action required. During our inspection visit we saw that an infection control issue affecting one ward was discussed at the daily meeting and effectively dealt with.

### Environment and equipment

- The layout of wards was generally good, allowing sufficient space and access, and mostly ensuring it was possible to closely observe patients who needed this. However, we found that a waiting area in the medical assessment unit (Ward 1) was out of sight of staff and had no call buzzers for patients to use. We saw a patient in the waiting area who had been sent to the unit by their GP because of breathlessness. The patient did not have a call buzzer to alert staff if needed.
- We saw that some areas were cluttered during our visit. Wards 15 and 16 were cluttered with equipment, and the corridor on Ward 1 was partly obstructed by two empty beds.
- There was 24-hour access to pressure-relieving equipment, including specialist beds.
- Staff told us there was sufficient equipment to meet patients' needs and that additional equipment was made available if necessary. Staff told us that repairs to and maintenance of equipment and facilities were usually carried out promptly when needed.
- Resuscitation equipment was available and accessible on the wards. This equipment was checked regularly, and records of these checks were complete and up to date.
- Appropriate systems were in place to deal safely with clinical and contaminated waste. However, we saw that cytotoxic waste on the Macmillan Cancer Unit was stored in a room that was not locked. There was therefore a risk of unauthorised access to this hazardous waste.
- We found that not all store rooms were locked shut, presenting risks that patients or visitors may enter these staff only areas and come into contact with chemicals and equipment. For example, in the McMillan day unit, we found the cleaning store was not locked and a bottle of toilet cleaner was not locked away. This chemical was an irritant to skin and eyes. We also found that the sluice room was not locked and flammable chemicals had not been locked away in the cupboards provided in this room. We also found sharps boxes in this unlocked sluice that contained used needles and syringes.
- Whilst on Ward 7, we found the kitchen area door was propped open with a wedge: the door had a sign on it saying "Fire Door, keep shut".

### Medicines

- The hospital used a comprehensive prescription and medication administration record chart for patients that facilitated the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for six out of 54 patients on two wards. We saw that appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed that people were getting their medicines when they needed them; there were no gaps in the administration records, and any reasons for not giving people their medicines were recorded. This meant that people were receiving their medicines as prescribed. If people were allergic to any medicines, this was recorded on their prescription chart.
- Medicines, including those requiring cool storage, were stored appropriately. Records showed that medicines were kept at the correct temperature, so would be fit for use. We saw that controlled drugs were stored and managed appropriately. Emergency medicines were available for use, and there was evidence that these were checked regularly.
- There was a pharmacy top-up service for ward stock, and other medicines were ordered on an individual basis. Patients therefore had access to medicines when they needed them.
- A pharmacist visited all wards daily. We saw pharmacy staff check that patients were taking the correct medicines when they were admitted, and that records were up to date. Pharmacy staff were also available on the wards to provide medicines to patients on discharge. Patients were therefore usually not kept waiting unduly for their medicines.

- Nursing staff told us that junior doctors were usually available during weekdays when needed to prescribe medication. However, staff said they frequently had to wait a long time for doctors in the evenings and at weekends. Patients were therefore often left waiting for essential medication such as pain relief or antibiotics.
- In the MacMillan day unit, we found four containers of cytotoxic medication for disposal left in an unlocked sluice room. Staff confirmed that it was trust policy that these medicines for disposal should be kept locked away.

### Records

- Generally we found patients' records were kept securely and could be located promptly when needed. Lockable trolleys were used for medical records on all the wards we visited, although we did find some occasions when the notes trolleys were unlocked. We found two occasions where medical notes were left unattended, for example on a nurses station.
- Nursing notes were kept at the end of beds so they were easily accessible for staff.
- We reviewed a mix of nursing and medical records for 60 patients across all the wards we visited. The standard and consistency of records varied widely. Some patients' records were well completed with full details of the patients' needs. In other patients' records we found: assessment documents left blank or with few details completed, fluid balance charts not fully completed, records of food eaten by patients not completed at every meal time, illegible handwritten entries and entries not signed. This lack of appropriate information in patients' records meant that patients were not protected against the risks of unsafe or inappropriate care and treatment.
- We saw that issues about records not being fully or correctly completed were identified on the monthly ward metrics reports.
- The monthly reports from May to September 2014 showed that some issues were not improving. For example, cumulative totals on fluid balance charts were poorly completed on most medical inpatient wards, falling below the trust's target of 90% completed for the whole period.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that staff asked patients before assisting them with personal care. There was evidence in patients' records of appropriate verbal and written consent.
- Some staff told us they had received training about the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). This was included in training about the care of people living with dementia.
- Most of the nurses we spoke with had a basic awareness and understanding of the MCA and DoLS. We saw that DoLS had been used appropriately to safeguard patients. We found that healthcare assistants generally had less understanding of the MCA and DoLS.
- We found that one patient with a learning disability had not had an assessment of their capacity to make specific decisions about their care and treatment. The patient's notes recorded that they had refused some treatment interventions and had attempted to leave the ward but had been brought back by staff. There was no evidence that staff had considered action such as assessing the patient's capacity, seeking advice from the lead nurse for safeguarding and learning disabilities, or using DoLS. We brought this patient to the attention of the ward manager during our visit, who immediately alerted the lead nurse for safeguarding and learning disabilities. The lead nurse later informed us that capacity assessments for specific decisions were underway with the patient.

### Safeguarding

- Staff told us about the procedures to follow if abuse of patients was suspected or alleged. Staff knew there was a trust lead person for safeguarding and how to contact the lead for advice and support.
- During our announced visit we heard an allegation of abuse of a patient on a ward we were visiting. We brought this to the attention of senior managers and saw that prompt and appropriate action was taken. We were told of measures to be put in place to protect patients against the risk of abuse.
- We heard allegations of neglect of a patient by a relative. We made a safeguarding alert to the local authority regarding this allegation. However, the incident did not meet the local authority criteria for safeguarding. The trust had already started an investigation, because staff

had reported the incident through the electronic system. The trust was continuing to look into issues raised by the incident, but the outcome was not yet known.

### Mandatory training

- The trust's target was for 85% of staff to complete mandatory training by the third quarter of the year. The data provided by the trust for August 2014 showed that only two medical inpatient wards had achieved this target: Ward 22 with 87% of staff having completed mandatory training and Ward 18 with 88%. Other wards ranged from 50% (Ward 15) to 83% (Ward 3).

### Management of deteriorating patients

- Patients were assessed for their risk of pressure ulcers, falls and inadequate nutrition, and for risks associated with moving and handling. We found that these assessments were generally completed on admission and reviewed at least every seven days, often more frequently.
- We saw that appropriate action was taken in response to the assessed risks, such as referral to a dietician where a patient was identified as at risk of inadequate nutrition. Patients assessed as at risk of falls had a magnetic sticker next to their beds to alert staff.
- All patients admitted to NHS hospitals should have an assessment of their risk of venous thromboembolism (VTE) (a blood clot in a vein), according to National Institute for Health and Care Excellence (NICE) guideline CG92. We found assessment forms in all the patient records we saw. The trust met the VTE assessment target, for example in July 2014, 97% of patients had a VTE assessment in place. Medical staff told us they always considered the risk of VTE for their patients on admission.
- The trust used the national early warning score (NEWS) tool, which is designed to identify patients whose condition is deteriorating. The tool is sensitive to physiological changes in the patient's condition and alerts staff by the use of a trigger score. Staff then seek appropriate advice and support. The early warning score charts in use incorporated a clear escalation policy and gave guidance about ensuring timely intervention by appropriately trained staff.
- We found that staff understood how to use the NEWS tool effectively. For example, we saw that a patient was noted by a healthcare assistant to have a slight rise in body temperature. The healthcare assistant informed the nurse in charge, who administered appropriate medication to the patient. Another patient noted to have significant changes in heart rate and blood pressure was referred to a doctor for further investigation and treatment.
- There was a rapid response team in the hospital that responded to calls from staff on the wards when a patient's condition significantly deteriorated. We saw that the rapid response team was used appropriately and effectively when needed.
- The daily 'huddle' meeting included discussion of patients receiving end of life care, patients who required specialist nursing – usually provided one to one, and any patients requiring support from the rapid response team.

### Nursing staffing

- The trust's risk register for the medical division identified low staffing levels as a high risk that could lead to poor patient experiences. The plans to mitigate the risk were on-going active recruitment of staff, including nurses and healthcare assistants, and the use of bank and agency staff.
- The planned and actual staffing levels were displayed on each ward we visited. During our announced visit we saw that most wards had achieved the planned staffing levels for that day. However, staff on most wards we visited told us it was a common to be short staffed, particularly at weekends. Nurses said they often stayed after the end of their shift to ensure that patients had the care they needed and to ensure that documentation was completed.
- We saw that bed occupancy rates at the hospital were consistently well above the England average. The bed occupancy rates were above 95% for 2013, while the England average remained below 90%. This meant the wards were nearly always full.
- During our unannounced visit, which was on a Sunday evening, significant shortfalls in staffing were affecting most wards in the hospital. Staff on one ward we visited were particularly concerned because the ward was already one nurse short and a nurse had been moved to another ward. The staff felt the ward was unsafe. The relatives of two patients on the ward were so concerned

that they felt unable to leave until they were certain that staffing was adequate. We saw that action was taken to improve the staffing, although the staffing level remained below that planned.

- On most of the wards we visited, patients and their relatives said they were aware of frequent staff shortages. Patients said, "A nurse will come to answer the buzzer, switch it off, then disappear for an hour!" and "We hear a lot of 'I'll be back in a minute' from the nurses" and "They're so busy all the time, I don't like to use the buzzer."
- Patients said the shortage of staff sometimes meant delays in getting assistance. One patient said, "I tell the nurses to go to the others first. I can wait a bit, but they need more help." The family of a patient felt that one family member had to be with the patient all the times, because the patient kept removing their oxygen mask. The family felt the nurses did not have time to ensure that the patient always had the oxygen mask in place. One of the family said, "It's not the nurses' fault, they're very caring, there are just not enough of them."
- We saw that the planned staffing levels had not always been achieved in the five months between May and September 2014. The trust's target was for 90% of shifts to be covered to the planned levels. This target was fully achieved by one of the 10 inpatient wards. The other wards had shortages of nurses or healthcare assistants each month.
- The trust had an average vacancy rate of 10% in Medicine, which was routinely being filled by bank and agency staff to ensure patient care was not compromised. The trust was actively recruiting to these vacancies, including the recruitment of newly qualified nurses. Whilst the newly qualified nurses could not undertake all of the roles and responsibilities of more experienced nurses they were fully supported with a year long preceptorship programme and a supernumery induction period.
- **Agency nurses were used to provide cover. The numbers of agency staff varied by ward, with some wards needing very low numbers representing just 2% of their monthly nursing cover. Other wards needed to use more agency nurses however the total percentage of agency used per month was less than 17%.**
- Staff told us that the use of bank or agency staff could create problems with the skill mix. Some agency and bank staff were not able to carry out the same tasks as permanent staff, such as taking blood. Bank or agency staff were not always familiar with the routines and requirements of individual wards, or with the documentation used, and so were not as effective as permanent staff.
- On Ward 22 there were seven registered nurses who were trained to give chemotherapy. The trust was flexible with its workforce and on the rare occasion additional nurses were needed, nurses working on the Macmillan Cancer Unit would provide cover. This had been highlighted on the divisional risk register and effective steps were being taken to manage the risk. There was an on-going training programme for chemotherapy nurses with additional nurses being trained every year.
- The daily 'huddle' meeting included identifying where there were staffing shortages and looking at possible solutions. We observed that certain wards were identified as 'hotspots' of over-staffing or understaffing. The staff from these wards met the bank staff administrator after the daily huddle, to look at reallocation of staff.
- The staffing situation was also reviewed at the afternoon clinical site managers' meeting and the evening handover 'hospital at night' meeting. We observed during our unannounced visit that staff were moved to the most understaffed wards wherever possible. However, planned staffing levels were still not met on all the wards.

### Medical staffing

- The proportion of medical consultants in the trust was in line with the England average for NHS trusts.
- The medical consultants were working and on call for periods of 24 hours during the week and 48 hours at weekends. This provided continuity for patients and staff. Junior doctors told us that they had good support from the more senior doctors and the consultants, including out of hours.
- Junior doctors told us that they were often very busy on weekend days and struggled to deal with all the demands on their time.

# Medical care (including older people's care)

- The workload for junior doctors at the weekends included accompanying the on-call consultant around the wards, completing discharge paperwork before the pharmacy deadline of 2pm, completing minor ward tasks such as prescriptions for fluids or pain relief, and managing acutely unwell patients. The phlebotomy service was limited at weekends, and this added to the doctors' workload. The junior doctors thought that another doctor should be available during the weekend days. The trust had already approved, at the start of 2014 a number of business cases to increase the medical staffing establishment. for the medical division, there had been £220,000 investment in 5 WTE medicine junior doctors and £150,000 investment in two WTE cardiology staff grade posts. In addition 4 extra consultants were approved to cover weekend working and provide support junior doctors." The trust was recruiting to these posts at the time of our inspection.
- Nursing staff told us they frequently had to wait a long time for doctors out of hours. They said this meant that patients were often left waiting for essential medication such as pain relief or antibiotics.
- We observed during our unannounced visit that the doctors were very busy and were constantly being called on by ward staff. Doctors told us they had to prioritise and go to the most acutely unwell patients first. Consequently, some patients had to wait for less urgent tasks to be done. This meant there was an increased risk of deterioration in some patients.
- We saw a patient who had been receiving fluids intravenously because they could not take fluids orally. The patient's intravenous cannula became dislodged on a Friday night and needed re-siting so they could continue to have fluids. No nurses on the ward were trained to do this at the time, and so doctors were asked to it. The doctors were aware of the patient, but had other higher priority patients to see first. The patient was left for more than 16 hours without fluids until the cannula was re-sited and the fluids could be given. The cannula was eventually re-sited by the ward sister, who was visiting the ward on a day off.

### Major incident awareness and training

- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff that may be called on to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency.

## Are medical care services effective?

**Requires improvement**

The monitoring of patients' food intake and fluid balance was often not properly recorded. This meant patients could be at risk of inadequate nutrition and dehydration. Policies and guidance for the care and treatment of patients were in line with national evidence-based best practice and professional standards. These policies and guidance were generally followed in the delivery of care and treatment, although with some exceptions.

Patients we spoke with were mostly satisfied with access to pain relief. However, the Cancer Patient Experience Survey 2012/13 indicated that hospital staff did not always do everything to help pain control all the time.

The trust participated in relevant national audits and used the results to inform developments and improvements in their service. The results of two national audits indicated that improvements were needed in services to patients with diabetes and stroke. The trust had plans to address the issues from both audits; however, because the plans were not fully achieved, we could not judge their effectiveness.

Staff had access to induction and training that was relevant to their role and the area they were working in. Agency staff did not have a formal induction and relied on permanent staff for orientation to the ward. The medical division had not achieved the trust's target for 85% staff to have an annual appraisal. Most wards were well below the target, notably Ward 2 with 54% and Ward 8 with 65%. (Performance appraisal is used to ensure that staff are competent to deliver care and treatment safely and to an appropriate standard.)

There was evidence of good multidisciplinary working on the wards. The trust worked collaboratively with external agencies such as the local authority when planning to discharge patients.

# Medical care (including older people's care)

### Evidence-based care and treatment

- The medical division used guidelines from the National Institute for Health and Care Excellence (NICE) and royal colleges to determine the treatment provided.
- Guidance from NICE was discussed at clinical governance meetings. Action required to meet guidance was planned and followed up.
- Trust policies based on NICE and royal college guidelines were available to staff and accessible on the trust's intranet site.
- The care and treatment of patients was generally in line with the trust's policies and procedures. We saw, for example, that staff followed the trust's policies for the use of protective equipment when providing help with personal care, and the policy for recording and reporting observations of patients' vital signs. However, the monitoring of food intake and fluid balance for patients was often not in line with the trust's policy and guidance.
- The endoscopy service was working towards accreditation with the Joint Advisory Group (JAG). (The JAG accreditation scheme is a patient-centred and workforce-focused scheme based on the principle of independent assessment against recognised standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and independent sector.)

### Pain relief

- Pain was monitored as part of the regular checks carried out by staff, usually every two hours. Patients confirmed that they were regularly asked by staff whether they were in pain.
- Pain assessments were included in the admission documentation for all patients, but were not always completed.
- Patients were able to request pain relief. Systems were in place to ensure that additional pain relief could be accessed if required.
- The majority of patients we spoke with had no concerns about how their pain was controlled, however one patient told us they were not given the pain relief medication they normally had at home which had caused them some distress.
- Feedback from patients as part of the Cancer Patient Experience Survey 2012/13 indicated that patients did not always have effective pain control. When patients were asked whether hospital staff did everything to help control pain all the time, the survey responses placed the trust in the bottom 20% of all trusts.

### Nutrition and hydration

- The malnutrition universal screening tool (MUST) was used to identify patients at risk of inadequate nutrition and dehydration. We saw that this assessment was completed in all the nursing records we looked at and appropriate action taken where patients were found to be at risk; this included referral to the dietician and speech and language therapist when needed.
- Patients identified as at risk of inadequate nutrition and dehydration were monitored to check their food and fluid intake. We found that records of food intake were frequently poorly completed. This meant that staff might not be alerted if a patient had not had sufficient food.
- Fluid intake and output charts were mostly completed, except for the daily totals, which were rarely recorded. (Accurate measurement and recording of fluid intake and output is important to the patient's wellbeing and provides early detection of fluid imbalance. Staff can then take appropriate action to avoid the patient becoming dehydrated or suffering other consequences of fluid imbalance.)
- Most patients were satisfied with the quality and choice of food and drinks provided. Patients said, "It's what you would expect in a hospital – it's not a five star hotel! There's a good choice for each meal" and, "I've had meals to suit me; I have to have soft food." A few patients were not satisfied with the food, and one patient said meals were often lukewarm when served. Patients commented that water jugs were replenished frequently and hot drinks were available. One patient said, "Tea whenever I want!"

### Patient outcomes

- There was a trust-wide annual audit programme for 2014/15 that included chronic heart failure management, National Diabetes Inpatient Audit, and the Sentinel Stroke National Audit Programme (SSNAP).
- The trust performed better than the England average for most of the in-hospital care and discharge indicators in

the Heart Failure Audit. (This audit collects data on patients with an unscheduled admission to hospital in England and Wales who are discharged with a primary diagnosis of heart failure. The audit aims to drive up the quality of the diagnosis, treatment and management of heart failure by collecting, analysing and disseminating data, and eventually to improve mortality and morbidity outcomes for heart failure patients.)

- The trust performed better than the England average for two of the three indicators in the Myocardial Ischemia National Audit Project (MINAP). This is a national clinical audit of the management of heart attack. The audit provides comparative data to help clinicians and managers monitor and improve the quality and outcomes of their services.
- The stroke services at Milton Keynes Hospital had been assessed as grade E by the SSNAP for October to December 2013 and January to March 2014. (The audit looks at a range of indicators and assesses stroke services as grades A–E, with E being the worst.) Some elements of the audit had improved in 2014, such as scanning and multidisciplinary working, although the overall assessment remained at grade E.
- The trust had recognised the issues in the stroke service and had plans in place to improve the quality of the service. This included investing in staff development and developing outreach services.
- The trust performed worse than the England median for all trusts for more than half the indicators in the National Diabetes Inpatient Audit (NaDIA). (NaDIA is a snapshot audit of diabetes inpatient care in England and Wales. The audit looks at whether the management of diabetes minimises the risk of avoidable complications, at harm resulting from the inpatient stay, and at patients' experience of the inpatient stay.)
- The trust had plans to improve the service for inpatients with diabetes. It had appointed two advanced nurse practitioners for the service and was planning to recruit two more. The trust had set up a multidisciplinary diabetic foot clinic, which was due to start in December 2014. The team for the clinic included a specialist diabetic nurse, a vascular surgery consultant, an orthopaedic consultant and a podiatrist.
- For patients with planned general medicine admissions and for patients with unplanned respiratory medicine admissions, the average length of stay was noticeably longer (worse) than the England average.

### Competent staff

- Staff received an induction that was appropriate to their role, responsibilities and the area they were working in.
- Staff were able to access training relevant to their role. Most staff had received training about the care of people living with dementia. We saw that elements of this training and guidance were in practice on the wards, such as the use of the 'This is me' booklet to gather and record relevant and useful information about the person. Staff working in the stroke unit had received bespoke training about the care and treatment of patients following a stroke.
- Ward staff told us they had concerns that some agency staff were not as competent as the permanent staff, and so were limited in the tasks they could undertake.
- Ward staff told us that there was limited induction for agency staff. Permanent staff gave the agency staff a tour of the ward, highlighting key points such as the location of the resuscitation trolley.
- The trust's target was for 85% of staff to have received an annual performance appraisal. For the medical division overall, 72% of staff had received an annual appraisal. In some wards and teams within the medical division, more than 85% of staff had received an appraisal – for example, the endoscopy unit with 96%, and the Phoenix rehabilitation ward with 92%. However, most wards were well below the 85% target, notably Ward 2 with 54% and Ward 8 with 65%.

### Multidisciplinary working

- There was clear evidence of multidisciplinary working on the wards. There was regular input from physiotherapists, occupational therapists, dieticians and other allied healthcare professionals when required.
- There was evidence of the trust working collaboratively with external agencies, such as the local authority, when planning to discharge patients.

# Medical care (including older people's care)

- Staff told us they had access to psychiatric support for patients when needed. We saw that a patient on one ward had been referred to and was seen promptly by a psychiatrist for advice and treatment.

### Seven-day services

- Consultant cover was provided every day. This included on-call cover out of hours and at weekends. Medical staff and nurses told us they were always able to get support from consultants when needed.
- Access to services such as x-ray and diagnostic imaging was available out of hours and at weekends. The hospital pharmacy was open until 3pm on Saturdays, although there was a deadline of 2pm for ordering medicines for patients being discharged to take home. A phlebotomy service was available at weekends (for obtaining blood samples from patients), although staff said this was a limited service. The endoscopy service was available for emergencies out of hours.
- Services such as physiotherapy, speech and language therapy and dieticians were available on an urgent on-call basis out of hours and at weekends.

### Access to information

- Medical and nursing staff had access to the information they needed to deliver effective care and treatment. Patients' records were kept in trolleys on the wards, located at or near the nurses' station. Nursing notes were kept at the end of each patient's bed.
- There were handovers for nurses and healthcare assistants between each shift. We saw that handovers were sufficiently detailed to ensure staff were aware of patients' needs and the priorities for care and treatment.
- Information was usually shared appropriately when patients moved between wards and services. We saw that patients were accompanied by a nurse when moving to a different ward, and details of the patient's needs, care and treatment were given to the receiving staff.
- Staff in the patient discharge unit said they did not always get all the information they needed, or were given incorrect information, when patients arrived from the wards. This included being told that patients' take-home medication had been ordered when it had not, and not being told about patients' limited cognitive abilities.

## Are medical care services caring?

Good

Overall, patients we spoke with were positive about the care they received from staff. A number of patients and visitors commented that staff did their best despite how busy they were and the pressure they were under. Patients felt that their dignity and privacy were respected, and described staff as kind and caring. We observed compassionate care on all the wards we visited.

The Friends and Family test was used and the results displayed in each ward. However, response rates were below the England average, scores were inconsistent, and the results were not displayed in a helpful or accessible way for patients and visitors.

### Compassionate care

- Most of the patients we spoke with were positive about the care provided by staff: "They're always cheerful and willing," "I can't fault them," "They're so kind – they can't do enough for you." A patient attending the Macmillan Cancer Unit said, "It's absolutely brilliant being a patient here."
- The patient discharge unit provided bags of food for patients who lived alone and who would not be able to do any shopping.
- Most of the patients commented that staff were always busy and wards were often short of staff. Patients said that this meant there were sometimes delays in getting assistance.
- A small number of patients or their relatives told us they had experienced or witnessed lack of caring and compassion by staff. When asked about the staff, one patient said, "Some caring – some terrible." The patient said they had seen that another patient was not given the help they needed to eat and drink.

# Medical care (including older people's care)

- Patients told us their privacy and dignity were respected. They said that staff always used curtains around the bed when assisting patients with personal care.
- We observed compassionate care of patients on all the wards we visited. We saw that patients' dignity and privacy were generally respected.
- There was a potential lack of privacy on the newly reorganised Ward 17, because female patients in one bay had to walk the length of the ward to get to a females' toilet. Also, another bay of female patients did not have a solid partition between the bay and the corridor. The ward sister told us that the trust were aware of these issues and work was planned to ensure patients' privacy.
- The trust used the Friends and Family test. This is a single-question survey that asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The average response rate for the Friends and Family test for the trust was 25%, which was below the England average of 30%. The average response rates for wards in the medical division varied widely, from 9% to 60% (from April 2013 to July 2014). The response scores (scores out of 100) also varied widely. For example, one ward scored 0, 100, 31, 22 and 63 in five consecutive months.

### Patient understanding and involvement

- The majority of patients we spoke with said they had been involved in making decisions about their care and treatment, and they had been given sufficient advice and information. They said they were given opportunities to ask questions about their care and treatment.
- The nursing and medical records had evidence of the involvement of patients or their relatives. There were notes of discussions with patients, including about their preferences regarding care and treatment.
- 'This is me' booklets were in use for patients with dementia. Staff completed this booklet with the help of the patient and/or their relatives or carers. The booklets were intended to help give staff a better understanding of the patient, by recording information such as details of routines and people important to the patient, how the patient communicates, and family history. We saw that the booklets varied in how well they were completed – some were very detailed, but others were brief and lacking in basic information such as the name by which the patient preferred to be called. This meant that staff might not have important and useful information to enable then to ensure patients' understanding and involvement.

### Emotional support

- Most patients and relatives said they felt able to talk to ward staff about any concerns they had, either about the patient's care or in general.
- We saw that counselling was available for patients; for example, a patient had been referred for counselling to help them to cope with a recent bereavement.
- Patients had access to clinical nurse specialists and specific teams for additional care and support, such as mental health, stroke, end of life and dementia.
- Rooms were available where private and sensitive discussions could take place with patients and/or relatives.
- Staff were prompted to ask patients on admission to hospital about any fears, worries or concerns they had. We found that this section of the admission documentation was frequently not completed or had very little detail.
- The trust's Macmillan service was part of the Milton Keynes Cancer Patient Partnership and was in the process of implementing a patient diary initiative to help support patients with the management of their conditions and treatments.

## Are medical care services responsive?

**Requires improvement**

There were significant problems with the flow of patients from the emergency department to the medical assessment unit and other wards, and the hospital bed occupancy rate was consistently high. Patients therefore often experienced long delays in being moved from the medical assessment unit to other wards. The trust had recognised the problem with patient flow and had plans in place to reorganise the emergency department and the medical assessment unit.

# Medical care (including older people's care)

Milton Keynes Hospital provides a range of medical services to meet the needs of local people. The health needs of most patients were met and there was access to specific support services such as mental health services and therapy support. Services were available to address patients' individual needs, such as interpreter services for patients without English as their first language, and lead nurses for patients living with dementia and for patients with a learning disability.

## Service planning and delivery to meet the needs of local people

- Medical services at Milton Keynes Hospital included specialist services to meet the needs of local people, such as the stroke unit, the haematology ward and the Macmillan Cancer Unit.
- A 24-hour telephone advice service was available for patients who were being treated with chemotherapy. Patients were provided with details of how to access the advice line, and staff had a policy and protocols to follow when patients used the service.
- A multidisciplinary diabetic foot clinic was planned to start in December 2014 for patients with diabetes.
- Two beds in the stroke unit were kept for patients diagnosed with a stroke, meaning that these two beds would not be used for other medical patients. However, we found that one of these beds was being used for a non-stroke patient. Staff told us this was because of the pressures on bed capacity throughout the hospital, and that the stroke unit was deemed the most appropriate place for the patient.

## Access and flow

- The trust had recognised the problem with patient flow and had plans in place to reorganise the emergency department and the medical assessment unit.
- Two wards were designated as Medical Admission Units, but one of these (Ward 2) was not used in this way. Ward 2 was operating as a general medical ward for male patients. Staff felt this had happened as a result of pressure for beds in the hospital.
- At the time of our inspection, the operational policy for the MAU was that patients would be there for a maximum of 72 hours. Patients would be discharged home or moved to appropriate wards within 72 hours of admission. However, we found that patients often stayed on MAU for more than 72 hours. One patient we spoke with had been on ward 1 for four days and did not know whether or when they would be transferring to another ward. Staff told us the delays in moving patients from MAU because of lack of beds available on the other medical wards.
- Bed occupancy rates in the hospital were consistently above the England average. The bed occupancy rates were above 95% for 2013, while the England average remained below 90%.
- The trust's performance for referral to treatment times was better than the England average for all trusts. Patients were waiting a maximum of 18 weeks between being referred and being seen for treatment.
- Medical outliers (patients under the care of medical consultants, but placed on other wards because of a lack of capacity on medical wards) were managed and monitored by their own consultants. Outliers were discussed at the bed capacity and management meetings each day so that patients could be moved onto medical wards whenever possible.
- Data from the trust showed that the average number of moves for patients once admitted was 1.34 in September 2014, although one patient had nine moves in that month. Most patients and relatives we spoke with had experienced few bed moves.
- Bed management meetings were held during the day and evening to discuss available beds and movement of patients between wards, and to look at all patients who could possibly be discharged from the hospital. We observed two of these meetings and saw comprehensive discussions about the management of admissions and discharges. Communication between staff attending the meeting was effective.
- The lead discharge coordinator met weekly with senior managers to discuss discharges and delays. The lead discharge coordinator also met weekly with the local clinical commissioning group to work together to speed up discharges. There were plans to also meet the housing and social services teams from the local authority.
- Most delays in discharges were because patients were waiting for care packages to be in place if returning to their own homes, or for a rehabilitation or care home place to be available.
- There was a patient discharge unit in the hospital, operating from 8am to 5pm Monday to Friday. A patient,

if medically and clinically discharged from a ward, could transfer to the discharge unit while waiting for final arrangements to be made, for example regarding transport or medication to take home. Beds could then be made available earlier for admissions. The discharge unit was staffed by qualified nursing staff who could continue the care of the patient. Staff told us that patients were sometimes kept waiting because their take-home medication had not been ordered before they were transferred to the discharge unit.

### Meeting people's individual needs

- An interpreter service was available for patients who did not have English as their first language. Staff told us they had used this service and found it easy to access. Staff in the patient discharge unit used flash cards as visual aids for patients who had difficulty in speaking or who did not speak English. Staff told us that a language interpretation service was available if needed.
- Staff knew how to get advice and support for patients who might need an advocate.
- Information leaflets about a range of treatments and procedures were available on the wards and on the trust's website. Some but not all leaflets were also available in large print, braille or languages other than English on request.
- There was a learning disabilities lead nurse for the trust, providing a service from Monday to Friday, from 9am to 5pm. Ward staff alerted the lead nurse if a patient with learning disabilities was admitted and if they wanted support or advice. This service was not available at weekends, and so any admissions after 5pm on Friday were not picked up until Monday morning.
- The trust had guidelines in place for the care of patients with dementia. The guidelines included screening all patients aged 75 years or older for dementia on admission to hospital. We found that this screening was not consistently carried out and some assessment forms were better completed than others. We saw two patient records where the screening had not been carried out, despite the patients being over 75 years old and having a history that could indicate dementia.
- There was a dementia lead nurse whose role included raising awareness of the needs of patients with dementia and of their carers, and leading on the development and implementation of relevant education and training for staff.
- 'This is me' booklets were in use on the wards to record significant information about patients with dementia. Patients were identified by a blue wristband and a blue magnetic forget-me-not flower sticker by their bed. The dementia lead nurse told us that an informal audit of the wards had shown that these items were not being used consistently. The dementia lead nurse responded by re-introducing the guidelines for patients with dementia and reinforcing this with posters on all the wards. Carers of patients with dementia reported that the guidelines were now being followed; we saw evidence of this on the wards we visited.
- The dementia lead nurse was carrying out a teaching programme on the wards, visiting each ward in turn to deliver a one-hour session open to all staff. The lead nurse said this session had been well received, and this was confirmed by staff we spoke with.
- Ward staff could refer patients to the dementia lead nurse if they felt the patient or the patient's carers needed advice or support. An example of this was a patient referred to the lead nurse because staff and the patient's carer found the patient's behaviour difficult to cope with. The lead nurse worked with the patient, the carer and staff to improve communication with the patient. The lead nurse also arranged for the patient's dog to visit the patient in hospital.
- We found that patients who were smokers were not routinely offered nicotine replacement therapy during their stay in hospital. Patients told us they had to walk out of the hospital building if they wanted to smoke, use an area where they knew they should not be smoking, or just go 'cold turkey'. Offering nicotine replacement therapy is a more compassionate approach and could also help patients to eventually give up smoking altogether.
- There was a potential lack of privacy on the newly reorganised Ward 17, because female patients in one bay had to walk the length of the ward to get to a females' toilet. Also, another bay of female patients did

not have a solid partition between the bay and the corridor. The ward sister told us that the trust were aware of these issues and work was planned to ensure patients' privacy.

### Learning from complaints and concerns

- Information for patients and visitors about how to make a complaint was displayed on each ward and was also available on the trust's website. No information was displayed about how many complaints had been made about each ward or what action had been taken in response to complaints and concerns.
- Most patients we spoke with had no complaints about their care or treatment. Patients or their relatives said they would feel able to raise complaints or concerns with ward staff and felt confident they would be listened to.
- Complaints, including informal and verbal complaints, were reported to the medical division governance meetings. The themes and trends were discussed at the governance meetings.
- Learning from complaints was passed on to staff through the trust's intranet, memos and team meetings. We saw a newsletter produced for the staff on MAU Ward 1 which included action for staff to take as a result of complaints received. On Ward 2 we saw information displayed in a staff area about learning from incidents and complaints.

## Are medical care services well-led?

Good

There was a strategy to reorganise services and facilities in the emergency department and medical division, including moving wards and reorganising the medical assessment unit. Staff had been consulted about the plans, although there were no definite dates for the plans to be achieved. Staff felt that a recent reorganisation of the cardiology service could have been better managed.

Suitable systems were in place for governance and risk management. Risks were reported at board level. Risks identified for the medical division were not always reviewed within timescales for action.

Staff told us they felt well supported by their immediate and more senior managers. Staff said the chief executive and senior managers were visible and approachable. Staff were generally positive about their roles and told us they enjoyed working at Milton Keynes Hospital.

Systems were in place to monitor the quality of the service provided, including seeking feedback from patients, visitors and staff. The results of quality assurance measures were not always displayed in a way that was easy to read or understand. Information, research-based evidence and patient feedback were used to improve services.

### Vision and strategy for this service

- The strategy for the medical division included a major reorganisation of services in the emergency department and medical assessment unit. This reorganisation was to facilitate a better patient flow and improve patient care. The plans also included other wards being moved or reorganised. Staff had been consulted and kept informed about the strategy and the plans for reorganisation, although there were no definite dates for the plans to be achieved.
- The inpatient cardiology service had recently been reorganised so that all cardiology patients, including those requiring more intensive care, were now located on Ward 17. Previously, patients were on various medical wards and a separate coronary care unit. The reorganisation meant that cardiology patients were all on one ward along with the cardiology consultants.

### Governance, risk management and quality measurement

- There was a risk register for the medical division, and processes were in place for escalating risks to the trust's board when required. Risks were discussed at the monthly governance meetings. There were 26 items identified as risks for the medical division. The review dates for four of these items had passed with no update being noted on the risk register.
- Complaints, incidents, audits and quality improvement projects were also discussed at the governance meetings, and action planned as required.
- Attendees at the daily 'huddle' meeting discussed current immediate risks and action needed. This meeting was attended by the head of operations and by

staff from all wards and from other teams such as the discharge team, estates and pharmacy. Staff told us that this meeting was an effective way of raising risks and getting appropriate action taken quickly.

- Systems were in place to assess, measure and monitor the quality of the service and to improve performance. Where issues were identified, feedback was given to staff and action was taken. However, the systems were not always effective. For example, the completion of fluid balance charts was monitored as part of the ward metrics information each month. We saw that the percentage of charts accurately and fully completed had consistently fallen below the trust's target on several wards in the previous five months.

### Leadership of service

- Staff said the chief executive and senior managers were visible and approachable. The chief executive met with new staff as part of their induction to the trust.
- We saw that matrons and ward managers were highly visible on the wards and departments we visited. Staff we spoke with told us they felt well supported and their managers were approachable and accessible. A ward clerk told us they had requested training about patients living with dementia because they felt this would be useful in their role. They told us that the ward sister "Has been excellent in organising this for me. She's been very accommodating when it comes to organising training and allowing time off for training." A doctor told us, "Senior support throughout the hospital is good and on the respiratory team it's excellent."

### Culture within the service

- Team working on the wards between staff of different disciplines and grades was good. Medical and nursing staff spoke highly of each other and reported that working relationships were effective and supportive.
- Most staff we spoke with were positive about their roles. Results of the trust-wide staff survey showed that findings were around the national average for areas such as job satisfaction, motivation at work, and staff being willing to recommend the trust as a place to work.
- Comments from staff included: "The best thing about working here is the patients," "Working here is good, and it's getting better" and, "Everyone is patient focused on here." One member of staff told us they had chosen to take a post at the hospital despite being offered a more senior role at another trust, because, "Milton Keynes is going up and up and up."

### Public and staff engagement

- The trust used the Friends and Family test, and results of this were displayed for each ward. However, the results were not presented in an accessible, prominent or meaningful way for patients and visitors.
- Patients commented that parking was plentiful but could be costly. A weekly parking pass was available that could reduce costs for some patients or visitors. However, the pass was not widely or prominently advertised or promoted.
- Maps were displayed in many places around the hospital site to help patients and visitors find their way around. The index to the maps was in small print and not in alphabetical order, so it was not easy to read and it was not easy to quickly locate a destination.
- The dementia lead nurse carried out a monthly survey of the carers of patients living with dementia. Carers were asked for their views of the care provided to the patient while in hospital and how well carers were involved in the patient's admission, care and discharge. The results were analysed for each quarter and action plans developed to address issues raised.
- The endoscopy unit had carried out audits in 2013 and 2014 to assess patients' perception of and satisfaction with the service. A report of the results was displayed in the waiting area of the unit so that patients could see what issues were raised and what action had been taken. Patients were generally very satisfied with the service and made positive comments about the care and support they received from staff.
- Results of the staff survey were not available at service level. The trust-wide results showed that findings were around the national average in most areas. Findings were negative for staff agreeing that their role made a difference to patients, for effective team working, and for staff receiving training, learning or development relevant to their job.
- There was a very strong and effective patient partnership group within cancer services. Staff worked

in partnership with this group to bring about improvements to patient care. For example, they had worked together to develop a patient diary for patients to complete throughout their treatment.

### Innovation, improvement and sustainability

- We saw that staff had used information, research-based evidence and patient feedback to improve services.
- Staff on Ward 2 told us that all patients with a pressure ulcer assessed as grade 2 were now on a strict regime of a change of position at least every two hours. Staff said this had resulted in a reduction in the number of patients whose pressure ulcers deteriorated from grade 2 to grade 3 or 4.
- Staff spoke positively of the training, support and advice provided by the lead nurse for dementia. Staff we spoke with were familiar with the trust's strategy for the care of patients with dementia, and they felt that the strategy had improved care for these patients.
- The respiratory medicine service had been developed so that patients no longer had to travel to other hospitals for some treatment and procedures. Further developments were planned to provide an integrated service with community services for patients with respiratory problems.
- A new pathway for managing the deteriorating patient was being trialled on Wards 15 and 16. The aim was to ensure patients who were deteriorating or at risk of deteriorating were quickly identified and urgent action taken. Staff said the new pathway had been active for a few weeks and they were still making changes, but felt positive it would improve patient outcomes.

# Surgery

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Outstanding |
| Overall | Good |

## Information about the service

Milton Keynes Hospital NHS Foundation Trust provides both elective and emergency surgery to the population of Milton Keynes and surrounding areas of south Northamptonshire and north-west Bedfordshire.

The surgical directorate provides 120 inpatient beds across four ward areas to a population which had grown considerably since the hospital opened. The clinical service units include musculoskeletal, head and neck, general surgery, theatres and anaesthetics, and outpatient units. The surgical directorate has designated anaesthetic and operating theatres, with an associated recovery unit.

We visited preassessment, the day surgery unit, operating theatres and the recovery unit. All surgical wards were visited, including the surgical assessment unit (SAU), general surgery (Ward 20) and trauma/orthopaedic (Ward 21). We also visited day surgery and ambulatory care.

During our inspection we spoke with 31 patients and four visiting relatives. We also spoke with 45 staff from various surgical-related roles and held group discussions with student nurses and trainee doctors. We spoke with members of the public at a listening event before our site visit. Over the two days of our inspection, we reviewed treatment and care records for 27 patients and observed the interactions of staff with patients during the course of their activities. We also reviewed the arrangements in place to support the delivery of elective and emergency surgery, including the environment and provision of resources. We considered in full email information sent to us after our inspection visit, and we followed up on information during an unannounced visit to the theatre department on Sunday, 2 November 2014.

# Surgery

## Summary of findings

Overall we rated surgery as good and the leadership as outstanding. There were good arrangements in place for reporting adverse events and for learning from these on surgical wards.

There were vacancies in all surgical areas but there were arrangements in place to ensure sufficient numbers of skilled and knowledgeable staff were on duty to meet the needs of patients.

The environment was suitably clean.

Consent was sought from patients and best interest decisions had been made where capacity needs required this. Patients received consultant-led care and staff had access to relevant expertise for advice and guidance. Procedures were in place to continuously monitor patient safety and recommended guidance was followed for surgical practices and patient care.

Surgical outcomes were generally good and were monitored and information was communicated through the governance arrangements to the trust board.

Patients reflected on their experiences of the care provided and commented favourably with regard to the attention received and caring nature of staff.

Patients who had physical and mental health needs, including care needs associated with living with dementia were supported by staff that had been trained in these areas. The nutritional needs of patients were addressed and people's religious, cultural and medical dietary needs were met.

The surgical staff considered the leadership of their services to be led by respected and committed individuals, with a shared vision and responsibility to provide excellent care to their patients. Staff were aware of the trusts values and focus on being a caring organisation. Trainee doctors and nurses found the surgical directorate to be a good place to develop their learning and skills.

The governance arrangements supported an effective process for reporting incidents, for reviewing these and identifying ongoing risks. Regular meetings with discussion and reporting enabled staff and representatives of the trust board to be informed and updated with regard to service delivery.

The views of the public and stakeholders was sought in relation to developing services. Staff were encouraged and supported to embrace change, try out new ways of working and to develop the service to benefit the local population.

# Surgery

## Are surgery services safe?

Good

Ward staff had a good understanding of and insight into the procedures for reporting, investigating and learning from near misses and adverse events. Some theatre staff were less able to describe the systems in place and did not recognise the value of reporting incidents and learning from reporting incidents. Theatre staff did not always follow recommended guidance following publication of safety alerts.

Monitoring of essential indicators of patient safety was taking place across ward areas, and results from such monitoring were made available to staff and reviewed as part of the quality and governance processes.

We checked a range of equipment used by patients to ensure that items were clean and appropriate for use. A number of chairs that patients sit on while showering were found on inspection to be unclean on the underside. On the orthopaedic ward, one shower stool was very rusty and not suitable for use because of the inability to clean it effectively. We looked at the hospital's policy for cleaning and decontaminating equipment used by patients, and found that the policy did not itemise equipment or identify how equipment should be cleaned. The cleaning logs we viewed did not include equipment used by patients, and therefore it was not part of the cleaning routine.

Surgical areas had vacancies within the nursing and theatre department teams; however, the arrangements in place ensured sufficient numbers of skilled and knowledgeable staff were on duty to safely meet the needs of patients. Theatre staff working on call at weekends did not always have sufficient rest between shifts.

Staff had access to and received training in safety-related subjects including safeguarding vulnerable people, mental capacity, resuscitation, and infection prevention and control. Staff also had training in subjects related to their roles, which enabled them to deliver safe care. Staff demonstrated their skills and knowledge from this training through their attention to safe procedures and adherence to hospital policies.

Arrangements were in place to ensure patients had access to prescribed medicines. The management of these medicines was in accordance with safe practices and legal requirements. Theatre staff did not always check the expiry dates on anaesthetic gases, and a number of gas cylinders were identified as having expired.

Clinical staff assessed and reviewed the needs of their patients at regular intervals to ensure patients received safe care. Records had been completed for each stage of treatment and care provided, and consent was sought from patients before investigations, treatment and care were carried out. The surgical and medical team were responsive in times of emergency, and staff always had access to consultant-led care for advice and guidance.

At times of high activity, there were procedures to follow in order that patients' safety and wellbeing were not compromised.

### Incidents

- A formal system was in use on all surgical wards for reporting incidents, near misses or errors. This was an electronic computer-based service that all staff could access.
- Ward staff we spoke with, including agency nurses, all had a full understanding of the process for reporting incidents and were able to provide examples of how the process worked from start to end, including where lessons learned had been shared. For example, improvements in pain management had been put in place for patients having joint replacement following a review of incidents.
- In response to incidents, patients at high risk of falls were identified by a yellow wristband, and staff requested lower beds and crash mats on the trauma and orthopaedic ward.
- Following a review of incidents of pressure ulcers, additional training had been provided in pressure area management and additional equipment purchased.
- Staff said the incident reporting system in theatre was being updated. Some theatre staff were less aware than others of the process for reporting incidents; in particular, they could not describe how they shared learning from incidents or adverse events and could not describe recent reported incidents.
- Where a serious incident had been reported on surgical areas, we saw a thorough process of investigating it, with input from various staff including the patient safety lead representative.

- The incident review process included consideration of the background to the event, contributory factors, care and service delivery problems, root cause and recommendations. Sharing of learning took place at ward meetings. Where relevant, the patient, their partner or next of kin had been provided with information from the reviews, subject to consent.
- The surgical directorate participated in the morbidity and mortality (M&M) group. The meetings provided opportunities to review all unexpected deaths and identify trends.
- We reviewed evidence of a full and informed approach to reviewing serious incidents where patients had undergone surgical procedures. Information included evidence of compliance with the duty of candour around informing relevant people at all stages of the patient's care, decision-making discussion and feedback after incident review.
- The hospital standardised mortality ratio (HSMR) is used to assess the ratio of the actual number of in-hospital deaths in a region or hospital to the number that would have been expected based on the types of patient a region or hospital treats. The surgical directorate reported an HSMR figure for the period up to July 2014 of 101.5 against a target of 100.

### Safety thermometer

- Each surgical ward area collected information on a range of safety parameters, based on individual patient risk assessments. The results were displayed on wards as part of the performance metric and included such information as number of inpatient falls, number of hospital-acquired pressure ulcers in each of the grading categories, and number of medication administration errors.
- We reviewed surgical ward safety thermometer figures for the months April to August 2014 and found that the main area of safety related to inpatient falls. For example, in May 2014 there were seven inpatient falls in Ward 21 and two in the surgical assessment unit (SAU). In August, there were four inpatient falls on Wards 20 and 21 and three on the SAU. Falls had also been reported on surgical wards for each of the other months.
- Figures for hospital-acquired pressure sores for the reporting period of April to August 2014 indicated that 11 patients had developed grade 2 pressure ulcers while receiving inpatient care.

### Cleanliness, infection control and hygiene

- The surgical division reported no cases of methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. difficile) up to the end of July 2014. A more recent case of C. difficile was reported on the orthopaedic and trauma ward.
- We noted that patients who required isolation were nursed in side rooms. Appropriate signage was in place to alert staff and visitors of the action to take.
- Patients were screened for MRSA pre-operatively and, when admitted as an emergency, as soon after admission as possible. This was in line with the local policy and recommendations of best practice outlined in national guidance. Patients who presented a possible risk were allocated to side rooms until swab results were known.
- The wards had infection-control champions who attended infection prevention and control meetings. We saw from minutes reviewed that the infection control lead nurse provided an update at the monthly meeting of matrons and sisters.
- Matrons undertook a Tuesday inspection, which included safety elements around cleanliness. Feedback was presented to wards and included areas requiring action. The ward sister was required to resolve any issues and provide an update on progress.
- There were separate clean preparation areas and facilities for removing used instruments from the operating room to the hospital's decontamination unit.
- Most patients we spoke with were satisfied with the level of cleanliness.
- We saw ward staff complying with best practice with regard to some infection prevention and control policies. For example, staff were observed to wash or gel their hands between patient care duties and when going about their activities on wards.
- There was access to hand-washing and drying facilities on wards and a good supply of personal protective equipment, which included gloves and aprons. Staff used personal protective equipment and disposed of it correctly afterwards.
- We noted there was no provision of hand sanitiser or soap in the dispenser in Room 10 of the preassessment clinic, and therefore could not be sure that staff were cleaning their hands between patients when in this room.
- Within theatres there was no alcohol gel on entry to anaesthetic rooms.

- Staff were adhering to the dress code, which was to be bare below the elbows, and followed correct technical procedures for scrubbing up before setting up the surgical instruments and commencing surgery.
- We also observed staff in all surgical areas following guidance for the safe disposal of different types of clinical and domestic waste and used sharps, and for handling contaminated linen.
- Surgical staff were seen to follow National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008). Ward staff reported they had not had any surgical site infections and that the consultants undertook audits in this area. The trust was not monitoring surgical site infections as part of its month-on-month performance reporting.
- We observed the environment in each of the surgical ward areas, preassessment rooms and operating theatres, and in the recovery unit. We found the standard of cleanliness to be generally good and saw domestic staff following guidance on required cleaning standards, practices and frequency. The exception to this was a desk used by nursing staff in a preassessment room, which we noted had unidentified splashes down the side, indicating a lack of attention to cleaning.
- We identified a concern with one of the shower rooms on the orthopaedic ward. There was evidence of poor sealant around the shower floor, and as a result the wall areas were moist and penetrable. This had an impact on the ability to clean the shower facilities thoroughly and presented a risk of cross contamination.
- Theatre corridors were cluttered with equipment, which had an impact on the ability to clean the floors easily.
- We checked a range of equipment used by patients to ensure that items were clean and appropriate for use. A number of chairs that patients sit on while showering were found on inspection to be unclean on the underside. On the orthopaedic ward, one shower stool was very rusty and not suitable for use because of the inability to clean it effectively.
- We looked at the hospital's policy for cleaning and decontaminating equipment used by patients, and found that the policy did not itemise equipment or identify how equipment should be cleaned. The cleaning logs we viewed did not include equipment used by patients, and therefore it was not part of the cleaning routine.

### Environment and equipment

- The ward environments varied in design and layout, with ambulatory care being the most modern of the wards.
- Single-sex accommodation was provided in bay areas, or wards were divided into two separate sides.
- The area around beds on Ward 20 was rather limited. If a patient was sitting in the bedside chair it was difficult to discuss information confidentially, because adjacent patients' chairs were almost touching. However, patients did not raise this as a concern when questioned.
- Operating departments were arranged as two phases, with four theatres in phase 1 and eight in phase 2, along with associated anaesthetic rooms, clean and dirty areas, and a recovery department with an area set aside for children.
- Ward-based staff reported having sufficient equipment to enable them to carry out their duties. They reported being able to request replacement items or new equipment, if required, with relative ease.
- Resuscitation equipment, including emergency drugs, was readily available in all surgical areas, including theatres, and had been routinely checked by staff in preparation for use. Technical equipment used for monitoring patients had been safety tested and stickers indicated the next date for checks to be made. Other equipment, including such items as patient hoists, had been serviced and was date stamped for the next required service checks.
- In theatres, we identified five cylinders containing nitrous oxide gas that had expired. Two of the cylinders had expired dates of October 2012. Staff were unaware of this, and it was only after we reported this that checks were made. (Anaesthetic staff have a responsibility as set out in the Association of Anaesthetists of Great Britain and Ireland safety guidelines Safe Management of Anaesthetic Related Equipment (2009)
- Staff reported having sufficient equipment to undertake their roles, despite the risk register mentioning theatre equipment as an issue, particularly laparoscopic/ endoscopic items.

### Records

- Patients' records were securely stored on each of the surgical wards we visited, with code-accessible locks for added security.

- Auditing of compliance with completing patients' care records was carried out monthly and formed part of the ward performance outcomes.
- We reviewed medical and nursing records and generally found most ward nurse records to be complete, with sufficient detail about the needs of each patient, and with pre-operative, intra-operative and postoperative information recorded.
- Omissions noted in a very few cases included lack of the nurse's signature at handover of the patient from recovery, and antibiotic allergies not noted in two records reviewed in theatre.
- Physiotherapy notes were very detailed. We were informed that audit of this aspect included peer review.
- Surgical patients' nursing notes were in a standardised booklet, with information recorded for all stages of the patient's journey. The booklet included risk assessments, such as relating to the risk of falls, pressure ulcers, venous thromboembolism (VTE) and nutritional needs. Most of the required sections had been completed in the patients' nursing records we reviewed.
- The VTE assessment was also required to be completed by the doctor before prescribing interventions such as anti-embolic stockings and prophylaxis for preventing blood clots. We found three patients' records where the patient had been prescribed prophylaxis but the doctor had not completed the assessment.
- We also noted gaps in a patient's record following surgery for fractured neck of femur, such as cement times not recorded in joint replacements, absence of discussion about the type of local block, and no checking allergies or recording blood haemoglobin levels. In addition, there were omissions with respect to anaesthetic postoperative instructions, and decisions to operate had not always been recorded.
- We saw good recording of pre-operative reviews by the orthogeriatrician, and daily medical follow-up by medical staff was well documented.
- Nursing metrics for each surgical area included indicators around compliance with nursing documentation. Our review of the data for September 2014 highlighted results consistent with some of our findings, with compliance of less than 80% in a number of areas. For example, Ward 21 scored 78% compliance for the documentation of patients' pain scores, and Ward 20 had completed the falls risk assessment in only 85% of the records reviewed. On the surgical assessment unit, the patient's repositioning chart was up to date in only 50% of records. The metrics did not provide any information to indicate how such discrepancies were to be addressed.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was undertaken in accordance with legal requirements.
- Patients who spoke with confirmed they had been given sufficient information to help them decide whether to proceed with investigations and surgical procedures.
- Patients reported they had signed a consent form before surgery and also verbally consented to blood tests and scans. We observed staff asking for consent both verbally and in writing.
- On checking patients' records we saw copies of signed consent forms, one of which related to a person who was unable to give consent because of capacity. In this case the patient's nominated representative, with lasting power of attorney, had signed the consent form on the patient's behalf.
- We saw that diagrams had been used to help patients understand the surgery.
- The surgical wards identified individual patients who had cognitive impairment and therefore required more staff engagement and support. A magnetic 'forget me not' sign was attached to the bedside locker. Family or friends who knew the person well were encouraged to complete 'This is me' documentation. Patients were also given a blue wristband to alert staff to their needs.
- Mental capacity assessments had been carried out on some surgical patients on Ward 21, and we saw Deprivation of Liberty Safeguards (DoLS) in place where required. We spoke with the lead person for safeguarding and DoLS, who informed us that staff were proactive in identifying patients who required a DoLS application. These were said to be acted on quickly, usually within seven days, although completed paperwork may follow the verbal agreement.
- Student nurses confirmed they had been trained about dementia and had a good awareness of 'forget me not' and the use of identity bands, as well as the 'This is me' document.

### Safeguarding

- Staff had access to guidance on safeguarding. The policy on safeguarding vulnerable adults detailed responsibilities and provided guidance on the actions

for staff to take. Staff confirmed that they had received safeguarding training as a mandatory subject and were aware of indicative signs and symptoms they would need to report. We saw that body maps were in use in patient notes to record bruising or other identified problems.

- The safeguarding team was accessible to staff. Our discussion with the safeguarding lead confirmed the processes that staff followed. The safeguarding lead was confident that staff were being proactive in identifying and reporting potential matters.

### Mandatory training

- Staff were expected to complete a range of mandatory training at various intervals. Subjects covered, for example: health and safety, moving and handling, infection prevention and control, equality and diversity, and basic life support. A formal system was used to monitor uptake of mandatory training, and senior staff were seen to be proactive in prompting staff who needed to attend. Some of the training was completed through booklets; ward sisters ensured that staff had access to these and that completed booklets were returned.
- Information about training attendance/completion was updated once a month on the electronic database, therefore details of recent training completed were not necessarily up to date. However, we found overall a good level of compliance, with some areas reaching above 90%.

### Management of deteriorating patients

- Clinical staff were seen to be following the five steps to safer surgery.
- Staff used a document based on the World Health Organization (WHO) safety procedures to safely manage each stage of a patient's journey from ward through anaesthetic, operating room and recovery. Such checks included marking of the operation site and checking what procedure a person was to have, including which teeth were to be extracted (if relevant).
- Information supplied to us before our inspection indicated that WHO checks had been completed in 100% of cases across the first four months of 2014 in theatres.
- We saw three different types of WHO checklist. In one of these, we noted that the surgical site inspection bundle had been removed from the checking form and no audit had been undertaken to identify the impact of this.
- We also observed that the dental checking process was inadequate; for example in one patient's case there was no mention of the specific tooth to be extracted until the handover after surgery in recovery. Three opportunities were missed to check the correct details of the surgery and confirm these with the surgical team. (Lack of checks can contribute to Never Events, which are situations that should not happen if correct procedures are followed.)
- In the theatre department we observed practices for monitoring patients while under anaesthesia. We found that staff were following the recommendations set out by the Association of Anaesthetists of Great Britain and Ireland.
- The trust had an updated policy for managing deteriorating patients, which the clinical board reviewed in September.
- We saw in the patient records we reviewed that staff were using an early warning system observation chart to assess, identify and respond to deteriorating patients. Staff monitored the condition of patients, including their heart rate, respiration and level of consciousness.
- We saw staff escalating a concern based on the escalation protocol and supplying details of the reason for calling, extra information to assist the team, assessment findings, their concerns and treatment plan. In our review of the patient's notes we saw evidence of the involvement of the rapid response team.
- Surgical staff used a sepsis screening tool as part of the assessment under the early warning system. This enabled them to alert medical staff to patients with clinical indicators of possible infection. We asked staff whether there was a protocol for managing patients with septic shock, and were told there was no such protocol, although staff said they followed guidance within the Royal Marsden Hospital Manual of Clinical Nursing Procedures
- Phase 1 theatres provided emergency arrangements. Access to a theatre was available 24 hours a day, seven days a week. A surgical booking form was completed by the surgeon and sent to the theatre coordinator, who was responsible for updating the emergency theatre list. The surgeon was responsible for contacting the anaesthetist on call.
- Morning 'huddle' meetings were used to identify and decide priorities for emergency surgery, taking into account obstetric cases and major trauma.

# Surgery

## Nursing staffing

- Senior nursing staff confirmed that they were able to use an acuity tool for assessing the dependency needs of patients against the available staff. Senior nursing staff said the tool was not used each day but was used periodically according to needs.
- Each ward area identified the staffing levels for each part of the day. The numbers of qualified and healthcare support staff were displayed for public viewing.
- The surgical division had vacancies for qualified nurses in all areas we visited, and had been trying to fill these over the previous months. For example, the orthopaedic and trauma ward (Ward 20) had 9.5 whole-time equivalent (WTE) nurse vacancies and 12 WTE healthcare worker vacancies.
- Retention was said to be very good, with many long-serving staff.
- We found that staffing levels were in line with expected numbers during our visit.
- When we reviewed rotas, we saw that arrangements had been made for backfill from bank or agency staff. Nurse to patient ratios were between 1:6 and 1:7 on surgical wards.
- The surgical assessment unit had recently introduced a different shift pattern, with staff working long days. Staff said this had improved staffing cover, with less reliance on agency staff.
- Surgical wards had a comprehensive handover between shifts, which we observed. The handover of confidential information and general safety details took place at the nurses' station, before bedside handover.
- During the bedside handover, we heard staff introduce themselves to patients and ask about their wellbeing. Staff followed a recently introduced initiative known as 'accountability handover'. This involved communicating information about the patient in association with reviewing recent risk assessments and patient observations, and medicines.
- The staff handing over to the nurse coming on duty signed a record accepting accountability for the information communicated and status of the patient record. This initiative had increased staff members' attention to detail, and ultimately patient outcomes had benefited.
- The skill mix of staff in surgical areas had been fully considered as part of the planning of rotas. Senior staff were always on duty to support junior staff, including sisters and matrons.
- Agency staff were used on most surgical wards and in theatre, and this was confirmed by our review of staff rotas and our discussions with staff.

## Medical staffing

- Surgical services were overseen and led by consultants for each 24-hour period. Arrangements were in place to ensure that the surgical directorate had access to and the support of consultant surgeons and anaesthetists during normal hours and out of hours, with on-call access for staff if needed. Information about the availability of surgical/medical staff and shift times was provided to ward and theatre areas, which ensured that appropriate support could be accessed.
- Elective surgery lists were covered by one surgeon, a registrar and one anaesthetist. Emergency cover included three surgeons on duty during the day, with two consultants responsible for acute admissions between 8am and 6pm from Monday to Friday, one on the ward and one in theatre.
- Handovers between all areas took place at the 'huddle' meeting, which was held each morning.

## Major incident awareness and training

- We looked at the trust-wide operational escalation plan, which included details of individual responsibilities, department-level communications and bed management (capacity meetings).
- We saw that escalation guides were available to senior nursing staff. The senior sister on the ambulatory care ward explained the ward's role in responding to major incident and bed capacity issues. The senior sister said they would send a nurse to the emergency department to assist, and that elective surgical cases may need to be cancelled. Additionally, patients may be received from Ward 21 in order to free its beds.

## Theatre staffing

- The trust's significant risk register identified issues of recruitment in theatres, particularly not having sufficient operating department practitioners with the right skills at band 5. Staff said this had resulted in more use of agency staff, with less continuity of care.
- Phase 1 and 2 theatres were managed by two band 7 staff, looking after 112 staff, with an operational manager overseeing the phase 1 and 2 theatres. A recent restructuring meant there were only four band 7 staff instead of seven, which had an impact on the support for junior staff.

# Surgery

- An expansion in the number of theatre staff had been approved by the executive board, which had agreed for 18 additional staff.
- Staff working patterns in theatres had changed to match the workload and patients' needs.
- Staffing in the recovery area was arranged around one-to-one care for children after surgery.
- Information received after our inspection indicated concerns about the Working Time Directive and the lack of rest between some working shifts. For example, a member of staff explained in their communication that the hospital policy stated that staff on call should have a total of 11 hours rest from 8.30pm onwards unless their call-out ended before midnight, when they were then expected in at their normal time. It was said that staff may have done an 8am to 8.30pm shift at the weekend then had to stay on until the early hours of the morning, with on-call ending at 8am.
- Our discussion with senior theatre staff during our unannounced visit clarified the arrangements for on-call staffing at weekends. We also reviewed the written arrangements in place. The aim was to facilitate as far as possible staff going home no later than midnight if they were returning to work the following morning. When this was not possible, staff were said to be given the Monday off.
- Staff had the option to opt out of the Working Time Directive.

## Are surgery services effective?

Good

Surgery services were effective. Surgeons, anaesthetists and clinical staff followed professional guidance, local policies and procedures, where appropriate, and monitored of compliance with these, including auditing the impact of such measures.

Patients reported that their pain was effectively managed by surgical staff. A range of supportive measures were in place to ensure that people's needs were addressed. This included providing access to specialist nurses and allied health professionals. Patients' nutritional needs were assessed by nursing staff and dieticians, where required, and patients were supported to eat and drink a balanced diet in accordance with their specific needs.

Surgical outcomes for patients were monitored and results contributed to a range of external comparative reports. Information relating to surgical outcomes and performance was communicated through the governance arrangements to the trust's board, providing oversight of the surgical division.

Clinical staff had a range of suitable skills, assessed through competency checks, which enabled them to undertake their duties effectively. The multidisciplinary team shared responsibility for meeting people's treatment and care needs through a seven-day service.

### Evidence-based care and treatment

- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons.
- The orthopaedic service complied with NICE guideline CG124: Hip fractures – The management of hip fractures in adults.
- Within the theatre department we saw staff adhering to NICE guidance on infection control and preventing surgical site infection.
- Clinical staff followed NICE guidance on falls prevention, fractured neck of femur, pressure area care and venous thromboembolism.
- Pre-operative investigations and assessment were carried out in accordance with NICE clinical guidelines.
- We observed evidence of staff providing care in line with NICE guidance CG50: Acutely ill patients in hospital, recognising and responding to acute illness.
- Patients receiving post-surgical care were nursed in accordance with the NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital.
- Staff had various procedures to follow for the management of patients. For example, we saw a protocol for managing patients with pancreatitis and guidelines on managing excessive blood loss.
- Local audits took place routinely on ward areas, with a focus on set standards for the delivery of care and on completing evidence to support this.
- Results of local audits formed part of the ward metrics and were reported at local level and upwards through the respective managers.
- We reviewed information reported about an audit of nurse-led activities relating to patient care across surgical wards from April to August 2014. This included,

for example, auditing the: recording and acting on triggers in response to concerns about a patient's physical condition; assessing the nutritional status of patients and action taken by staff to address patients' individual needs; and assessment of the skin integrity of patients. The latter included accurate completion of evidence to support the management of patients who were at risk of developing skin damage over pressure areas. Results indicated many areas where the target of 90% compliance was not met for documenting nurse-led activities and responsibilities. For example, we found scores of less than 80% for the completion of fluid intake/output charts in April 2014 on Wards 21, 22 and the surgical assessment unit. Similarly, results were under target in this measure for Wards 21 and 22 in July 2014. Failure to document patient-related observations and nurse activities may have a negative impact on patient outcomes.

### Pain relief

- Staff told us that patients who were identified during their pre-operative assessment as having their existing pain managed by high-dose opiates were made known to the pain team. This enabled subsequent pain management to be managed appropriately.
- Nursing staff were required to use a pain assessment score to assess the comfort of patients, both as part of their routine observations and a suitable time after giving a patient pain relief. We checked the nursing records to see how efficient nurses were at recording the assessments, and found that staff did not always record pain assessment scores on a consistent basis.
- We noted from the nursing metrics that the monitoring of compliance with pain assessment both before giving pain relief and after was identified as an area falling below expectations. For example, on the ambulatory care unit the pain score assessment for September 2014 achieved 74% compliance, and pain relief given to patients within 30 minutes achieved 70%.
- We asked patients whether their pain levels had been assessed by staff and whether they received pain-relief medication when they required it. All but one patient told us that staff asked about their pain regularly. Most said that their pain was managed well. Patients said they did not have to wait for tablets or pain-relief medicines.
- We checked medication charts and found that patients had been prescribed pain-relief medicines.We saw medication charts were completed in full.
- Patients and staff had access to an acute pain service that consisted of one very experienced and highly skilled nurse and a patient pathway manager.
- In discussions with the pain team we confirmed that support was available from the chronic pain team if needed and from the anaesthetic department. The service was supported by local trained staff, with a reliance on anaesthetists at weekends.
- The lead pain nurse had a responsibility to review all epidurals and patient-controlled analgesia pumps daily.
- We were advised that the rate of epidural usage had fallen from 800 to 200 per year, with greater use of patient-controlled analgesia for colorectal, urological and open gynaecological surgery. The management of pain in patients having elective surgery for hip and knee joint replacement was based on best practice from Scotland. This included using fentanyl patches, gabapentin with dexamethasone and ranitidine medicines.
- Spinal analgesia and fentanyl was also being used intra-operatively. Postoperative pain management also included four doses of intravenous Paracetamol in the first 24 hours.
- Effective pain relief enabled same-day mobilisation and contributed to the enhanced recovery pathway.

### Nutrition and hydration

- Nursing staff explained to us that patients who were to undergo surgical procedures followed variable guidance on starving before surgery, based on the anaesthetist's instructions rather than best practice guidance.
- Nutritional assessments were identified in each patient care record we reviewed. Where supportive measures were required, these had been identified, such as where a patient's food intake needed to be monitored or restricted.
- Involvement of the dietician was noted where relevant.
- Protected meal times were in place on surgical wards, enabling staff to help patients with minimal interruptions. Staff were noted to ring a bell 15 minutes before meals were served, which enabled staff to start to prepare their patients and themselves for serving meals.
- Patients who had a special diet or were not to have any food or drink by mouth were identifiable by the use of magnetic pictorial signs attached to the bedside locker.

- Those patients who required close monitoring based on the nutritional assessment were identifiable by the use of a red tray system, to ensure their needs were addressed by staff. We observed at breakfast time and lunch time that such individuals were provided with a good level of support.
- Staff were kind and respectful when supporting people to eat and drink and took sufficient time to enable patients to take their meals and drinks without being interrupted or hurried.
- We saw that a large pictorial menu was available for those with a cognitive or visual impairment. Special dietary needs were catered for: those associated with medical needs as well as cultural and religious choices.
- Patients who were required to have their fluid needs restricted or managed with other interventions, such as through an intravenous line, were monitored and their input and output was recorded on the fluid balance chart within their nursing record. Information was used to inform treatment and care delivery.
- With the exception of one patient, all those we spoke with described positively their experience of the food, including the quality, amount and choice available.
- One patient told us they felt hungry in the night because they had only been given two slices of toast after surgery. Their comments were relayed to the sister in charge, who arranged for the chef to see the person.

### Patient outcomes

- The trust reports data for the Summary Hospital-level Mortality Indicator (SHMI). This indicator reports on mortality at trust level across the NHS in England. The report is produced and published quarterly as an official statistic by the Health and Social Care Information Centre. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. Trust data for national reporting on the SHMI was 94.3, indicating that the outcomes for surgical patients were, in the main, within expected ranges.
- Good arrangements were in place to ensure that surgical outliers (patients who were under the care of surgical doctors but were placed on a ward with a different speciality) had their treatment and care overseen by staff with the appropriate specialty expertise. For example, we were told that gynaecology patients placed on the surgical assessment unit were reviewed every day by the specialty team. We saw gynaecology patients being reviewed by the specialty team while we were on the ward.
- The trust's performance in the National Bowel Cancer Audit 2013 indicated worse than average scores for the reporting of computerised tomography (CT) scans, with a score of 69.6% against an England average score of 89.1%. However, the trust performed better in three areas; Case ascertainment rate: 90% (England average 86%); Patient discussed at Multi-Disciplinary team meeting: 100% (England average 97.8%); Patient seen by clinical nurse specialist: 94.8%, (England average 97.7%).
- We noted when we reviewed the information in the National Bowel Cancer Audit that the trust had questioned the reliability of information, because one of the surgeons included had not submitted data for the respective period.
- We reviewed information on comparative surgical outcomes, submitted for the National Joint Register. Information available includes data for the period 1 April 2003 to 1 July 2014. The data showed, for example, the 90-day mortality rate following hip surgery, based on the type of patients the hospital had seen. The national average 90-day mortality rate following primary hip replacement surgery is around 0.4%. The hospital's results for hip surgery did not indicate a higher mortality rate than expected.
- The National Hip Fracture Database report for 2013 included contributions from the trust. With the exceptions of surgery being performed within 48 hours and bone health medication assessment, the trust performed worse than the England average. The report indicated the following for the trust; **Admitted to orthopaedic care within 4 hours, 22.9% (England average 51.6%); Surgery within 24 hours, 90.2% (England average 87.3%); Pre-operative assessment by a geriatrician, 44% (England average 53.8%); Patients who developed a pressure sore, 6.4% (England average 3.5%).**
- The trust had measures in place to improve the results of the 2013 audit. These included a revised care pathway for patients who had a fractured neck of femur and the employment of an enhanced recovery lead who improved outcomes for patients.

- Readmission figures for elective urology and colorectal surgery, and non-elective general surgery and trauma or orthopaedic procedures were better than the England average.
- The trust scored worse than the England average in elective general surgery and non-elective urology readmissions. For example, the elective readmission rate for the period from April to October 2014 for general surgery was 5.91%.
- Patient-reported outcome measures for the period from April 2013 to December 2013 indicated improvements in patient outcomes for groin hernia surgery and hip and knee replacement.
- The trust reported positive results for the British Association of Day Surgery efficiency scores, achieving 90 against a target of 80.

### Competent staff

- Most of the patients we spoke with reported a high level of confidence in medical and nursing staff's knowledge and skills.
- Staff commented on the aspects of service that staff did well, including managing patients' care, caring for people with dementia, managing falls, shortening the length of stay and communicating with relatives.
- Trainee doctors reported feeling very well supported by senior staff and having good training opportunities.
- Nursing staff reported having very good training opportunities.
- Nursing staff undertook competency assessments in a number of areas, including venepuncture and cannulation. Additionally, clinical staff with extended roles had undertaken competency-based assessments to show they met the requirements of the role.
- We found that the surgical division was proactive in trying to address the discharge process, and a number of nursing staff were able to discharge patients following non-complex surgery. The trust's policy set out clearly the roles and responsibilities for this; we reviewed information outlining safety parameters to be met in making the decision.
- Nurses who were able to discharge patients were expected to complete approved training. In addition they were required to be assessed as competent to discharge patients, and had to accept responsibility and be accountable for their practice in this area.
- Within the ambulatory care ward, 98% of nursing staff had been assessed as competent in discharging patients. This had meant nurses could improve the patients experience and discharge patients in a more timely way.
- Ward staff confirmed they had opportunities for supervision, including preceptorship for newly qualified staff and a buddy arrangement for more experienced staff.
- Staff had opportunities in an annual review to discuss their performance and identify learning and development needs.
- We reviewed the figures for surgical staff appraisals. Rates of appraisal were high, with the lowest being in theatres (82%). Several areas had 100% of staff appraised.
- Student nurses gave positive reports of their learning opportunities at the trust, of staff being friendly towards them and of the good working relationship they saw between regular staff.

### Multidisciplinary working

- We found good multidisciplinary team (MDT) working across the surgical areas. One patient told us there was to be an MDT meeting the following day about their progress, and was aware the staff would be discussing the findings of tests.
- We observed the trauma unit multidisciplinary meeting taking place, which was attended by nursing staff, the discharge coordinator, physiotherapists and occupational therapists, and junior doctors and consultants.
- This was a ward round discussion of patient care, therapy and discharge planning for every patient on the ward. The discussion included care needs in the home, well in advance. After this meeting, the medical staff reviewed each patient, including new admissions, those going to theatre and patients with particular problems.
- We were informed that the pain team held MDT meetings weekly. They also held long-term post-discharge drop-in clinics with psychological support in the city centre, in conjunction with Citizens Advice.

### Seven-day services

- The expertise of a surgical consultant was accessible 24 hours a day, seven days a week, in the surgical

directorate. For example, trainee doctors told us that ward rounds were undertaken first thing every morning, seven days a week. These were attended by the consultant, registrar and senior house officer.

- During these rounds, all patients, including new admissions, were reviewed. Following this, a consultant-led ward round took place in which all new patients were seen, plus those going to theatre and any patients with particular problems.
- Junior doctors told us that radiology support was very good at all times although they indicated that the ultrasound cover for the 'hot clinics' could be improved.
- There was evidence of prompt access to magnetic resonance imaging (MRI) and reporting of the findings in respect of a patient who was admitted in the evening and received the scan at 9pm. This enabled a rapid discharge with required pain relief and reassurance from the orthopaedic ward.
- The physiotherapists and occupational therapists told us that, in addition to Monday-to-Friday provision, physiotherapy was available at weekends for trauma and orthopaedic patients.
- On-call provision of physiotherapy was available 24 hours a day, seven days a week, for patients with respiratory conditions.
- Occupational therapy was only available on weekdays.
- Staffing levels for both physiotherapy and occupational therapy services were on the risk register. The current staffing establishment was regarded as inadequate for the growing workload.

## Are surgery services caring?

Good

Patients described their own treatment and care positively, and we received many favourable comments. Comments included, "Staff are fantastic" and "The nurses and doctors here have done a tremendous job; the nurses are lovely and I can't fault them." One patient told us about the care of two other patients in their ward area, which they had observed to be less than acceptable. Their concerns related to lack of attention and responsiveness of staff towards two less-able individuals.

We saw staff were kind, compassionate and caring towards people. Staff demonstrated very good communication skills and were attentive to people's needs, providing support and care with courtesy and respect. Patients told us that staff respected their privacy and dignity, and we saw that staff ensured privacy by closing curtains around bed areas and shutting bathroom doors while personal care was being delivered.

Patients told us they had been given detailed information by doctors and nurses so they understood their treatment and care options and could make informed decisions. Information was accessible in a range of formats, and translation and audiology services were available to support the delivery of information.

### Compassionate care

- Patients who spoke with us on all the surgical ward areas we visited commented positively on the caring nature of staff towards them as individuals, with comments such as, "Staff are wonderful, they try their best," "Staff are fantastic" and "The nurses and doctors here have done a tremendous job; the nurses are lovely and I can't fault them."
- One patient, however, expressed concerns about the manner in which two elderly and unwell patients (medical patients) were treated by individual nursing staff on the surgical assessment unit. Their concerns related to the reluctance of a healthcare support worker to help a person in need, and staff not attending to another person who required help after being given pre-investigation bowel medicine. This patient reported to us that some of the day staff were "shocking, with a slightly disinterested attitude". These comments were communicated to the nurse in charge for action.
- Another patient said the staff were very busy but were "friendly, much better than a previous admission" and staff "were more communicative".
- A patient commented on the medical staff, saying, "The consultant is very nice" and, "Junior doctors are lovely, very caring and always sorry when they have to take my blood."
- All the patients we spoke to said they would be happy to recommend the hospital to their friends and family.
- Where constructive comments were made, these related to the level of noise at night on some wards, with staff talking and laughing or placing care records back in the storage unit on the end of the bed in a noisy manner.
- Some patients found the varied uniforms to be confusing and thought they made it difficult to identify staff grades and roles.

# Surgery

- Patients told us they were treated with respect by staff and their dignity and privacy was taken into account at all times. One patient said, “They have absolute respect for me and my partner,” adding that this was an improvement on the previous time they used the hospital.
- Patients said the staff were “friendly and introduced themselves”.
- We observed staff to be kind, caring and attentive in their duties, providing information and clarification in response to questions. Staff were unhurried and took their time to support those less able with aspects of care such as walking and eating and drinking.
- We saw staff introduce themselves as part of the bedside handover at the change of shifts.
- We noted that staff closed privacy curtains and spoke in lower tones when discussing confidential information.
- Staff completed two-hourly checks on patients, in which they assessed their level of comfort and whether they needed to change position or required assistance to use the toilet. They also checked the patient’s ability to reach their drink and call bell. These checks were recorded on a record known as ‘We care around the clock’.
- Friends and Family test results were displayed on each ward we visited. Average scores were presented in respect of the feedback received. Overall, the scores indicated positive responses on each ward. For example, scores out of five for dignity and respect, involvement, information and cleanliness.
- Supporting comments made by the respondents were not displayed and therefore people were unable to see what had been reported or what action was taken by staff to address issues. We were however able to review some of the comments made in respect to the ambulatory care ward, which the sister said would be shared with staff. These included; ‘Great nursing staff and junior doctors’, ‘No domestic for four days’, patients cleaning the WC’, ‘Extremely welcoming team and handover very professional’.

### Patient understanding and involvement

- Patients who spoke with us said they had been provided with information in a way that they were able to understand. Comments included: “I have felt well informed,” and “All procedures have been explained fully.”
- Patients reported having tests and investigations explained to them and getting feedback on these in a timely manner. One patient said, “They can’t do enough for me. I have been given information and they have done lots of tests and told me the results.”
- Relatives who spoke with us in the presence of the patients endorsed the comments made about the standards of care.

### Emotional support

- Patients and staff had access to a range of clinical nurse specialists in each surgical area. For example, we saw evidence of the involvement of a specialist stoma care nurse, diabetic nurse and tissue viability nurse. We also saw information that indicated the involvement of the mental health hospital liaison team.
- Nursing assessment both pre-operatively and throughout the patient’s hospital stay included consideration of each person’s emotional needs, such as any particular worries or fears. We saw nurses spending time with patients discussing progress and responding to questions in a calm and caring manner.
- Staff told us the trust did not have a designated counselling service, but confirmed there was access to clinical psychologists if needed. Patients also had access to the hospital chaplaincy for spiritual, religious or pastoral care. The patient experience team was available to provide advice, support and receive feedback on the experiences patients had. Information about the hospital chaplaincy and patient experience team was provided in admission booklets.

## Are surgery services responsive?

Good

Overall, people using the surgical services had their needs met by responsive staff. Suitable arrangements were in place to deliver the service. Services were reviewed to ensure the local community’s needs were being met. New services had been or were being put in place where improvements were identified as being beneficial to patients’ experiences and outcomes.

People who required emergency surgery had access to operating theatres that functioned outside normal working hours. There was access to diagnostic services and appropriate clinical expertise; ensuring staff were

responsive to people's individual needs. Referral to treatment times were generally in line with the England average. Arrangements were in place to ensure that patients' care was led by staff with the right surgical expertise, and that clinical decisions were made accordingly. There was access to specialist advisers, including nursing and other allied medical personnel.

The percentage of fractured neck of femur patients seen and operated on within 48 hours was above the England average at 90.2%.

People's diverse needs were taken into account in planning treatment and care. Physical or mental health needs, including care needs associated with dementia, were supported by staff that had been trained in these areas. The 'forget me not' scheme was seen to be active, and staff were proactive in making sure the experiences of people with dementia were good.

Arrangements were in place to identify complaints or concerns and deal with these before they went into formal complaints. Staff received information about the concerns identified, and responded where actions were required.

### Service planning and delivery to meet the needs of local people

- Services within the surgical directorate had been established to provide elective and emergency care needs to a population which had grown considerably since the hospital opened. The main challenge identified in surgical areas related to recruitment, particularly in high activity areas, such as trauma and orthopaedics and operating theatres. Service planning around this had included recent changes to staff working patterns in some areas.
- Surgical services were available 24/7, with emergency access to operating theatres outside of normal working hours.

### Access and flow

- The time from referral to treatment was broadly in line with the England average. The trust was meeting the standard for general surgery, ear, nose and throat surgery, ophthalmology and thoracic medicine.
- Standards for the time from referral to treatment were not being met for trauma and orthopaedics, urology and oral surgery.
- Patients were admitted to the hospital for surgery after referral by their GP to the relevant consultant and subsequent booking of elective surgery. Patients could also be admitted from A&E as an emergency, or as a direct admission by their GP.
- Elective surgery patients attended the preassessment clinics, where all patients who were expected to have a general anaesthetic procedure were seen by the preassessment sister.
- An anaesthetist was present in the department two days a week and could see individuals presenting with identified problems or discuss more complex cases.
- A one-stop service was available, in which patients who were seen by the consultant surgeons as an outpatient were listed for surgery and seen in the preassessment clinic straight from their consultation.
- Staff reported to us that 75% of patients were booked in using the one-stop process. In addition, some patients received their pre-assessment over the telephone, based on an agreed list of questions. We were told that 524 patients had been pre-assessed in this manner between January and December 2013.
- Patients were only admitted for day surgery if they met specific criteria, including not having any higher risks such as high blood pressure, a history of heart attack in the previous year, insulin-controlled diabetes or respiratory problems.
- Staff reported that the day surgical ward was busy, with patients arriving at the start of the morning and afternoon list all at once. The staff said that patients all arriving at the same time put them under pressure, and that staggered arrivals would enable them to undertake their responsibilities more effectively.
- The present arrangements meant staff collected patients from theatre at the same time as they discharged patients and admitted patients for afternoon lists. Often, therefore, the department closed late; for example, the previous evening it should have closed at 8pm but did not close until 10pm.
- Staff confirmed that if a day-case patient's needs changed as a result of the surgical procedure or being unwell postoperatively, theatre staff would find a ward-based inpatient bed for the patient.
- We observed a very good model of care led by a band 8 nurse who managed the 'hot clinic' based in the surgical assessment unit. This service was accessed through the

patient's GP or directly from A&E. The 'hot clinic' service provided responsive treatment and care to address the immediate needs of patients without them needing to be admitted.

- The hot clinic nurse was able to arrange blood investigations and ultrasound scans and was able to assess and discharge patients independently. The nurse was also able to perform minor procedures, having undertaken extended skills training.
- An enhanced recovery sister in the surgical division led on the patient recovery pathway and provided support. The enhanced recovery process aimed to reduce the length of stay, which at the time of our inspection was three to five days, with a target of three days.
- The programme included the provision of pre-operative information and education for patients around, for example, preparation for surgery.
- Since January 2013, the percentage of cancelled operations not treated within 28 days was worse than the England average in two periods. However, for the first four months of 2014. 100% of cancelled operations were subsequently completed within 28 days, which indicated an improving picture. We were told that cancelled patients were seen by the coordinator and given a new date for their surgery.
- Information supplied to us indicated that 52 elective surgical activity sessions had been cancelled as of the end of July 2014. The target for the year to date was 32.
- We noted an upward trend in the number of elective surgery cancellations.
- We also saw an upward trend for elective surgical activity that was cancelled on the day. The target for the year to date was 5%, but 6.1% of activity had been cancelled on the day by the end of July 2014. A lack of beds were said to be the main factors in cancelled sessions.
- Staff working in theatre advised us that a tracking system was used for scheduled patients, and the list of patients was available two weeks in advance. This was used with the aim of fully utilising operating lists and identifying potential empty slots on the lists.
- We found that the efficiency of theatres had increased over the first three months of 2014/15. **Efficiency** had improved in July to **87.1%.** At its worst, theatre efficiency was **58.3% in April** 2014
- The percentage of fractured neck of femur patients seen and operated on within 48 hours was above the England average at 90.2%.
- Surgical staff advised us that there were surgical outliers at times (i.e. patients who were not placed on the surgical specialty ward); for example, on the day of our visit to the trauma and orthopaedic ward there was one outlier. Such patients were said to be minor cases, including for example a fractured wrist. The trauma coordinator had a responsibility to try and find a bed back on a surgical ward.
- Nursing staff commented to us on the lack of on-going community care provision. Two patients had also commented that their discharge was delayed because they were awaiting beds for their on-going rehabilitation.
- Bed occupancy overnight within the trust was 96.2% for quarter one, as reported to NHS England, which was considerably higher than England average of just over 88%. This overnight bed occupancy led to lack of availability of beds at times and subsequent cancellation of elective surgery. We saw from information presented in the surgical divisional dashboard up to the end of July 2014 that 136 patients above the age of 75 had been moved to a different bed between 10pm and 7am.

### Meeting people's individual needs

- Patients told us that staff had met their individual needs and respected their decisions and choices.
- Patients told us they were frustrated they were not allowed to use personal IT devices. They were also concerned about a lack of functioning televisions and the cost of paying to watch TV.
- Staff told us about the 'three W' project – water, warmth and warning – which related to staff making sure every patient had fluids (where not restricted), was comfortable and warm, and could reach their call bell. We saw that staff were proactive in making sure the three "Ws" were met.
- We witnessed good communication and team working around planning the discharge of patients, with advice given to the patient and their GP.
- Nursing staff said discharge planning started when patients were admitted.
- Delays to discharges were said to be mainly related to external factors, such as community-based needs and lack of rehabilitation beds.

- Nursing staff told us that almost half the patients on the orthopaedic and trauma ward were waiting for rehabilitation beds.
- A named individual from the community-based service had a responsibility for supporting the patient pathway for patients with learning disabilities. The head of nursing confirmed that staff were proactive in making reasonable adjustments and could facilitate a preadmission walk-about for the patient to reduce anxiety and explain procedures. The trust encouraged carers or family members to stay with patients who had particular needs or accompany them to theatre.
- The dementia lead informed us they were developing the service with the aim of providing increased awareness to staff.
- The dementia lead told us that staff in pre-assessment were good at identifying individuals who might need more support, and they then worked with the team to provide appropriate care.
- We saw staff have positive interactions with patients who were living with dementia, including staff calming an unsettled patient using good communication skills and appropriate interventional strategies.
- The trust had a draft dementia strategy that included giving clinicians responsibility to assess for dementia all patients over 75 years of age who had not previously been assessed. There were trigger points for staff to note and act on within the adult admission assessment process.
- Staff had access to dementia training; 48% of staff on the orthopaedic and trauma ward had undertaken a relevant course.
- There was access to the orthogeriatrician for elderly patients who had been admitted with orthopaedic matters.

### Learning from complaints and concerns

- We reviewed information given to us that suggested that most complaints were around poor communication, the discharge arrangements, lack of empathy and compassion from nurses, and the poor manner of some doctors. Information reviewed contained details of action taken as a result of the complaints, including direct discussion with staff.
- Sisters reported they saw each patient every day to troubleshoot and avoid complaints escalating. We were told that formal complaints were sent to ward managers for investigation, and replies to these came from the chief executive officer.
- We saw minutes from staff meetings, including the surgery division's day surgery forum and preassessment team meeting, where key performance indicators had been discussed, which included complaints and compliments and areas for improvement. Suggestions for improving the patient experience had been put forward around, for example, staggering the admissions for day surgery.

## Are surgery services well-led?

**Outstanding** ☆

Surgical services were led by highly respected, committed and enthusiastic staff. Senior surgical staff demonstrated passion and responsibility for providing excellent service to their patients and to supporting staff in their roles. Surgical staff regarded their leadership very highly, with most staff commenting on the leadership's visibility and efficient and effective communication.

Staff were aware of and understood the values of the trust and demonstrated enthusiasm for and commitment to the provision of a quality service to patients. Surgical areas had embraced the need to change and develop, and a number of quality improvements were in place, with monitoring of progress and reporting to a range of committees and the trust board.

Governance arrangements identified risks and provided regular monitoring of these, with progress on action plans reported at directorate meetings. Regular detailed reporting enabled senior managers and representatives of the trust's board to be aware of performance and of where improvements had had a positive impact on service delivery.

Trainee doctors and student nurses considered the surgical areas to provide good experience and opportunities for learning and developing their skills.

# Surgery

## Vision and strategy for this service

- Our observation of and discussions with staff working in surgical areas confirmed that staff were committed to the trust's focus and underpinning values. There was a good awareness of the focus on improving patient safety, improving the patient experience and clinical effectiveness.
- The trust's strategic business plan dated 29 May 2013 identified areas to be addressed over a three-year programme, and included a focus on elective surgery. The plan recognised the competition from local independent sector services. Six surgical specialties had been identified as having significant activity in the independent sector, including trauma and orthopaedics, gastroenterology and general surgery.
- The business plan addressed various areas, including streamlining the theatre pathway and greater efficiency in all respects of the elective and non-elective surgical pathway.
- We reviewed information about a project that aimed to improve the planning and organisation of elective surgery and thus improve patient care. This work was led by the medical director with input from named individuals and was on-going.
- The surgical division had worked with key partnership organisations to develop and agree its operational plan for elective surgical care. We reviewed the surgical directorate's operational resilience plan for elective care for 2014/15 and noted that the principles underpinning this included ensuring that patients received high quality care, that care was "right, first time" and that care was closer to home.

## Governance, risk management and quality measurement

- The governance arrangements included key responsibilities held by the three directorate leads, referred to as the 'triumvirate'. The three directorate leads confirmed they worked on a monthly cycle of board meetings and divisional clinical specialty unit (CSU) meetings.
- We reviewed minutes of divisional monthly meetings, including those of 3 September 2014, in which we noted tactical planning had been discussed. This had a focus on improving aspects of the surgical service, including reducing waiting times, reducing cancellations because of lack of bed availability, reducing surgical outliers and reducing the number of over or under booked operating lists.
- Monthly patient safety and risk management reports were produced. We saw from the anaesthetic group's meetings report for September 2014 that the meeting addressed various areas including complaints, compliments and serious incidents, National Institute for Health and Care Excellence (NICE) guidelines, audit and their risk register.
- The surgical directorate was accountable to the executive team and had its performance reviewed by them.
- Executive team meetings were used as an opportunity to develop staff; a different CSU lead was invited to each meeting to present a topic of their choice. Presentations to the executive team were said to be about achievements or about their needs, such as the need for support from an orthogeriatrician and the emergency surgery pathway. Staff had been able to say how this would impact on patient pathways or outcomes, providing the executives with an insight as well as enabling the executive to present challenges back to CSU.
- Governance arrangements included discussion of serious incidents as part of the 'grand rounds' carried out. Grand rounds provide an opportunity for the multidisciplinary team to discuss cases of interest, and are open to all hospital staff.
- Senior nursing staff were aware of specific issues that had been identified on the risk register, including, for example, staffing levels and recruitment. The trust's senior nurses' meeting was well represented by the surgical directorate. Minutes reviewed indicated discussion around various governance issues, such as pharmacy and infection control.

## Leadership of service

- The surgical directorate was led by the clinical director, head of nursing for surgery and the general manager for surgery, as a 'triumvirate'. The directorate included CSUs for head and neck, musculoskeletal, general surgery, theatres and anaesthetics, and outpatients. Each area operated as a hub, with responsibility for performance and monthly reporting to respective leads. The triumvirate met weekly for both formal and informal

discussion; it also met formally before board meetings. In terms of representing the surgical directorate, the triumvirate had voting rights on the management board and decision-making responsibilities.

- Ward based staff gave a consistent message of confidence in the leadership arrangements and feeling well-led in each of their respective areas. Staff respected those in leadership roles and thought highly of them.
- Staff had undertaken or were undertaking an active leadership programme. This programme had a positive impact on the individual staff and those they were supporting. For example, staff said the leaders were approachable and listened to them.
- Members of the executive team were visible to staff, knew staff names and communicated effectively and in a respectful manner.
- Weekly newsletters were posted and daily messages from senior staff were disseminated throughout the surgical division.
- Trainee doctors told us that the chief executive officer personally invited trainee doctors to management meetings, and that the management was receptive to junior doctor's ideas for improvement.
- The junior doctors reported strong team working from the chief executive officer and through the entire organisation.
- The organisation recognised the need to change in response to the altering population. The chief executive officer was said to drive the direction of change.

### Culture within the service

- Staff told us about the values in the 'We care' programme and its aims in relation to improving patient safety, the patient experience and clinical effectiveness.
- Staff reported feeling valued and listened to, and this reflected on the delivery of care to their patients.
- We observed a culture of staff involvement and active engagement with one another, aimed at improving the patient experience. Champions for individual areas such as falls, nutrition, dignity and respect helped staff to optimise patient care. Senior managers within the surgical division had high praise for the staff. We were told, "We are proud of what we have done and of our teams," with managers citing examples of staff members' contributions.

### Public and staff engagement

- Staff working on surgical wards reported positive staff engagement at all levels. Comments made about senior managers included, "I am really impressed" and, referring to the head of nursing, "She makes it her business to see us."
- The chief executive officer was reported to be "brilliant and down to earth". Staff said they were encouraged to attend road shows and they were encouraged to email or speak directly with the chief executive officer. In addition, staff reported that they always had feedback to questions or comments.
- Senior managers said that the contribution of staff was acknowledged through the surgical staff award scheme, certificates and a monthly trophy, for which anyone could be nominated. Staff were invited to divisional meetings, and a surgical newsletter provided information to staff.
- Matrons worked at night so they could meet with a see staff. This was seen as important so night staff also felt valued and supported.

### Innovation, improvement and sustainability

- We were told about and saw minutes from a meeting held in September 2014 in which the problem of bringing patients back to the trauma and orthopaedic ward after surgery had been discussed. We saw from the discussion that a plan of action had been agreed, with the aim of reducing delays in discharge from recovery, and that this was due to start on 27 October for a trial period of three months.
- The trauma and orthopaedic services had enhanced the patient recovery pathway through the fragility advanced nurse practitioner (FANP), who coordinated trauma work. Improvements to the patients experience and patient outcomes had been achieved for fractured neck of femur patients since this role had started.
- The FANP nurse spoke about the areas of focus, which included audit on infection control in patients with a cognitive impairment, nutritional needs, analgesia and early mobilisation. They also spoke about the impact of the measures that had been implemented and showed us the figures to demonstrate this impact. Outcomes of the work undertaken had been presented at a conference, and poster presentations had been made to staff to share details of progress.
- We were told about a presentation that had been made at the executive meeting, which subsequently led to

improvements in the emergency surgery pathway. Concerns had been highlighted about safety levels at evenings and weekends, which led to immediate funding to address this and additional staff had been recruited into this post.

- A matron-led initiative had involved a wide range of people carrying out a sensory walk-around. This identified areas where there were issues for people with hearing problems or visual impairment, and subsequently led to a change of colours on signage to yellow and black. Other practical improvements included cutting trees back on walkways, providing hearing loops at all reception desks, training in signing for receptionists, and letters for eye clinic patients produced in large print.
- Within the ambulatory care unit, a nurse had recently started a designated role in a nurse led clinic, where they were able to perform ear nose and throat micro-suction. We saw there that a room was provided for this treatment, reducing the need for patients to go to outpatients or be re-admitted.
- The surgical directorate leads explained how the establishment of 'hot clinics' had contributed greatly to improved patient pathways.

# Critical care

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

The critical care service includes the areas where patients received more intensive monitoring and treatment for life-threatening conditions. The service provides specialist expertise and facilities for the support of vital functions. The trust provides 24 critical care beds, 15 beds in the neonatal unit (NNU) and nine beds for adults in the Department of Critical Care (DOCC). During our inspection we visited the DOCC. The findings of our inspection of the NNU are reported within the children and young people's section of this report.

The DOCC provides level 3 care for patients who require either advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. The DOCC also provides level 2 intensive care, which is high-dependency care.

Patients at level 1, which means they are at risk of their condition deteriorating, or those recently relocated from higher levels of care, are managed in other areas of the hospital, such as on a medical ward. The staff caring for level 1 patients receive support and advice from the critical care outreach team known as the rapid response team. The rapid response team is available 24 hours a day.

During our inspection visit we spoke with five (out of six) patients in the department as well as three relatives. We also spoke with 28 staff, who included nurses, doctors, allied health professionals, support staff, domestic staff and managers. We observed care and treatment and looked at records, including those of patients receiving care. Before the inspection, we reviewed performance information about the hospital and gathered feedback from staff and patients at our focus groups and listening events.

# Critical care

## Summary of findings

We rated critical care services at Milton Keynes Hospital NHS Foundation Trust as 'good'.

Reliable and effective arrangements were in place to keep patients safe. Nursing and medical staffing levels were in line with the core standards for intensive care units, 2013. Staff consistently identified, reported, acted upon and learned from safety incidents and risks.

Generally, occupancy rates within the Department of Critical Care (DOCC) were in line with national averages for the period from May 2013 to July 2014, meeting the Intensive Care National Audit and Research Centre (ICNARC) 2012/13 indicators. During that period, bed occupancy exceeded the national average on three occasions.

The care, treatment and support of patients was delivered in line with current national standards and best practice. Patient outcomes were routinely monitored and measured, shared internally and externally, and used to make improvements to the service. There was evidence of collaborative working between the multidisciplinary team and with other health and social care providers. Staff were appropriately recruited, trained and supervised, engaged in peer review, and sought and acted on expert advice where appropriate. Recruitment was ongoing for some nursing vacancies, and there were some gaps in the completion of mandatory training.

Patients and those close to them were involved in decisions about their care and treatment, and were

able to seek information. Staff treated people with kindness, dignity and respect, and showed an encouraging and supportive attitude. One relative wrote, "We were particularly touched by the empathy and compassion that nurses and doctors showed (our relative)." Effective arrangements were in place to ensure patient confidentiality.

The critical care service was generally responsive to the needs of patients. However, the core standard to have processes in place to ensure that the rehabilitation needs of all people are assessed within 24 hours of admission was not being met. Managers were aware of this need and showed us plans to implement processes in December 2014. Clear clinical records were maintained; these records confirmed that care and treatment was provided in a way that met people's individual requirements. Access to the department was based on clinical need, including for people who needed planned critical care following surgery. A range of written information was available for patients and those close to them; however this was not visible in other languages or an easy-read format.

Staff were generally positive about improvements to the culture and leadership within the department and trust following recent management changes. Managers described clinical leadership within the department as, "dynamic, enthusiastic and patient focused". Staff referred to the smooth running of the department and were positive about managers being approachable and accessible. An effective governance and quality assurance framework was in place to ensure innovation and the improvement of services.

# Critical care

## Are critical care services safe?

Good

Effective systems and processes were in place to keep people safe.

Staff understood their responsibilities to raise concerns and record safety incidents and near misses. Patient safety incidents were raised through the trust's online reporting system, and we saw that learning from these reports took place. Up-to-date safety databases and dashboards were in place, and we saw that Safety Thermometer indicators had a low incidence in all categories.

Staffing levels were generally in line with the core standards for intensive care units, 2013. The department was visibly clean, and infection control and prevention policies were generally being followed.

Regular and consistent checks were made on equipment to ensure it was maintained and remained fit for purpose. Faulty equipment was labelled as out of use, and a log of requested actions was maintained. However, we saw that a bath and shower were decommissioned, but could not see any evidence that this had been reported to the estates department responsible for repair or was being acted upon.

Risks relating to delayed discharges, environmental risks and some staffing issues were identified on the local risk register and escalated to the corporate risk register. Work to resolve the identified risks remained on-going.

### Incidents

- There were clear requirements for staff to report incidents on the trust's electronic reporting system. Staff understood their lines of accountability and told us they were encouraged to report and learn from incidents.
- Actions and lessons learned from incidents were shared through staff meetings, one-to-one meetings with line managers, emails, newsletters and verbal handover reports.
- We noted the number of incidents that had occurred in the unit were on display for patients, staff and visitors.
- No Never Events or serious incidents were reported on the unit during 2013/14.

### Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. Safety Thermometer information was clearly displayed for staff, patients and visitors. This included information collected on blood clots (venous thromboembolism), falls, pressure ulcers and infections.
- One patient fall was recorded between July 2013 and July 2014, and two catheter-acquired urinary tract infections in the same period.
- Data showed patients had risk assessments in place for the prevention of pressure ulcers , falls prevention and malnutrition.

### Cleanliness, infection control and hygiene

- The environment was visibly clean and was odour free. We saw that surfaces and mattresses were clean.
- Curtains were disposable, and dates for changing had been indicated on them.
- Staff were able to demonstrate and explain the procedures for cleaning and the audit systems in place to ensure the premises were kept clean. Written instructions and audits were in place that demonstrated high levels of compliance.
- We saw that all staff were 'bare below the elbows' and followed the trust's policies in hand washing and the use of protective aprons and disposable gloves to minimise the risk of cross infection.
- The service had effective arrangements in place to dispose of clinical waste and sharp objects.
- There was a daily clinical ward round with the microbiologist. Records we looked at showed that staff from the microbiology department were also called on between times for advice and support.
- We saw staff follow the appropriate isolation procedures when caring for a patient with an infection.
- We saw from audit information that levels of compliance with hand hygiene standards were consistently high.
- Hand-washing facilities and hand-wash gels were readily available for patients, staff and visitors in all areas we visited, and were being consistently used throughout our visit.
- One staff toilet had inadequate hand-washing facilities, which we brought to the attention of the nurse in charge; the nurse addressed this straight away.
- All patients in the unit had their methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile

(C. difficile) status checked as part of the Safety Thermometer reporting. (C. difficile and MRSA are bacteria responsible for infections that may be picked up by patients in hospitals and can sometimes be difficult to treat.) No instances of C. difficile or MRSA had been reported on the unit in the last 12 months.

### Environment and equipment

- The environment was bright and spacious, with adequate space between each bed.
- Although we did not see any bariatric equipment in place, staff told us that it was available.
- Equipment such as pressure relieving mattresses were easily available. We had no concerns about the availability of relevant equipment within the unit. There was sufficient equipment for monitoring and treating patients to meet their needs.
- Records showed that regular and consistent equipment checks and stock control checks were carried out to ensure that patients were not at risk of harm from unsuitable or unsafe equipment.
- Emergency equipment was available for adults and children, and was clearly labelled. All staff were able to show us the location of emergency equipment and evidence that expiry dates were checked regularly.
- Safety alerts relating to equipment were received and communicated to relevant staff in a timely manner and acted upon.
- Faulty equipment was labelled as out of use, and a log of requested actions maintained. However, we saw a bath and shower that were decommissioned, but could not see any evidence that this had been reported to the estates department responsible for repair. Patients were having to use the relatives' bathroom outside the main area of the unit if they required a bath or shower.

### Medicines

- The number of hours for which the pharmacist attended the unit fell below the requirements of the core standards for critical care units. However, the pharmacist was supported by a pharmacy technician who attended the unit. Staff told us they received a good service and had not experienced any problems accessing medicines or advice and support from the pharmacist.
- We saw that medicines, including those requiring additional security (controlled drugs), were generally stored safely in the designated areas and reconciled correctly in accordance with legal requirements. However, we saw seven medicines that were not stored in their original packaging.
- Processes for the receipt of controlled drugs were not always carried out in accordance with the trust's policy. In the records we checked, this had happened on nine out of 32 occasions. We brought these matters to the immediate attention of the unit pharmacist, and corrective action was taken.
- We observed staff giving medicines and medicinal gases in a person-centred way and with the appropriate safety checks carried out, and recording their administration.
- Medicines that required refrigeration were safely stored in designated fridges. Records of the daily checks of the temperatures of the fridges showed that temperatures were consistently within the required range.
- There had been no medicated reported incidents reports on the unit in the past year.

### Records

- We reviewed the records for five patients and saw that the electronic and paper-based systems were coordinated.
- Records were completed and stored in accordance with the trust's policies.
- Records were designed in a way that allowed essential information to be documented, for example about allergies, medical history and current medication. Records also contained treatment and care plans and evidence of discussions with patients and those appointed to act in their best interest, where applicable.
- Safety goals and risk assessments were documented, acted upon and evaluated, for example relating to falls, pressure ulcers and nutrition screening.
- Records demonstrated individualised care and we saw there was evidence of regular communication with patients relatives.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' records showed that consent to care and treatment had been obtained from patients or their relatives where necessary.
- Staff demonstrated that they had received training and guidance in the Mental Capacity Act 2005, and gave examples of when patients may lack capacity to give informed consent. We saw evidence of mental capacity and best interest decision assessments taking place.

# Critical care

- No patients were affected by the Deprivation of Liberty Safeguards (DoLS) at the time of our visit. However, staff demonstrated to us their awareness of DoLS and knew who to contact for further guidance.

## Safeguarding

- Staff we spoke with demonstrated a good understanding of what safeguarding meant in practice, the procedures they would follow, and what constituted safeguarding concerns.
- Staff provided us with a recent example of a safeguarding alert to the local authority. This example also demonstrated collaborative working with the safeguarding lead for the trust as well as with other relevant professionals and services.
- Staff had completed safeguarding training in line with the trust's policy.

## Mandatory training

- Arrangements were in place for staff to attend mandatory training. We were shown the unit's staff training matrix. Mandatory training included basic life support, safe moving and handling of patients, prevention and control of infection, resuscitation and safeguarding.
- Records confirmed that 81% of mandatory training had been completed. Managers were aware of the gaps, and arrangements were in place to ensure that compliance increased.

## Management of deteriorating patients

- Staff in the department maintained an up-to-date local risk register. The following risks were identified and escalated to the corporate risk register: delayed discharges, environmental risks and staffing issues.
- The national early warning score (NEWS) was in use when the staff were preparing a patients to go to a ward in the hospital. This made it easier for ward staff nurses to see the observations of the patient. (NEWS is a scoring tool that identifies risks that a patient's condition may be deteriorating.)
- The NEWS score was not used within the unit because they were transferred over to the critical care documentation. Staff were trained and competent to care for patients whose condition was deteriorating.
- Staff we spoke with were able to describe the action they would take if they identified that a patient's condition was deteriorating. We had no concerns about the arrangements that were in place.
- The unit provided a critical care outreach team which they referred to as the rapid response team. The team provided support for patients who required level one care across the hospital. The team worked 24 hours a day, seven days a week.

## Nursing staffing

- Levels of medical and nursing staff were safe and related to the dependency of patients. We found that levels were generally in accordance with national guidance in the core standards for intensive care units, 2013, and the 2014 guidelines from the National Institute for Health and Care Excellence (NICE) in the Safer Nursing Care Tool.
- A lead nurse (matron) had overall responsibility for the nursing elements of the service and was supported by band 7 nurses (senior sisters).
- A band 7 nurse was allocated to most shifts, ensuring there was a supernumerary shift coordinator. There were some occasions when this no band 7 nurse was allocated because of sickness, but staff did not think this had a negative impact on the service.
- There were five nursing vacancies at the time of our visit. Staff told us about some ongoing challenges with recruitment. Shortages of nursing staff were handled by redeploying staff from other areas within the trust or by using temporary (bank and agency) staff. Effective arrangements were in place for the induction and orientation of temporary staff.
- We saw there had been nursing recruitment taking place and three band five nurses, one band 6 sister and 1 health care assistant were due to commence employment in December 2014. This meant the unit would have no nursing vacancies.
- An advanced nurse practitioner was employed to support the critical care team in their learning and their application of evidence-based practice. Staff spoke positively of the impact this had on improvement and innovation, not just for nursing practice, but across the wider clinical team.

## Medical staffing

- There was a designated clinical director and lead for intensive care. Consultants in intensive care were available 24 hours a day, seven days a week, and undertook at least twice-daily clinical rounds.
- The work patterns of consultants and other grades of doctor met those in the core standards for intensive care units, 2013.

# Critical care

## Are critical care services effective?

Good

From the data we reviewed, our observations and the conversations we had with staff, patients and relatives, we judged the service in the unit to be effective. We found that the care delivered adhered to national and best practice guidance.

The service was effective at monitoring, managing and improving patient outcomes. We saw a range of audits that had taken place and action plans in place to ensure continuous improvement.

Staff were qualified and competent to carry out their roles safely and effectively. Suitable arrangements were in place for recruitment, supervision and learning and development.

Patients were confident in the staff's abilities to deliver high quality treatment and care. There was clear evidence of staff working collaboratively as a multidisciplinary team.

### Evidence-based care and treatment

- The assessment, care and treatment of patients were generally delivered in line with current national standards and evidence-based guidelines including recognised research and the national core standards for intensive care units, 2013.
- Care bundles were used for skin care, ventilator care and the management of sepsis. (Care bundles are groupings of best practice regarding care intervention.) These were audited in patients' notes and outcomes shared with nurses and doctors at handover report and acted upon.
- There was evidence that the department had contributed to research programmes outside mandatory submissions. These included an interim review of the level 1 pathway (a package of measures for adult patients to ensure that high risk patients are proactively monitored, treated and effectively transferred to higher levels of care).
- The department had enrolled in the Breathe study designed to compare two different ways of helping someone come off the ventilator (a process known as weaning). However, the department had not been able to recruit any participants at the time of our visit.

### Pain relief

- Records showed that patients' observations included documentation about their pain. Staff used a standardised pain scoring tool to assess people's pain.
- We observed that medicine for pain relief was administered only if it had been prescribed by the doctor, and that it was documented in the medicines administration record and clinical notes. Pain relief medicine was monitored regularly, and we saw that nurses, doctors and pharmacists reviewed pain relief together with patients.
- Records we looked at showed clear links between patients' pain scores and the level of pain relief medication given.
- All patients had their nutritional needs assessed, documented and acted upon, including a consideration of their weight and their risk of malnutrition and dehydration, using the malnutrition universal screening tool (MUST).
- Records showed that fluid monitoring was in place for patients, demonstrating hourly and daily input. Fluid balance was calculated and acted upon.
- National and local guidelines for the provision and assessment of nutrition, including enteral nutrition, were provided for staff. The records we looked at confirmed that guidelines were being followed.
- Patients were offered a choice of menu and assisted in making choices. Snacks were provided between meal times.
- We observed that food hygiene and storage was in accordance with national standards.
- All patients had the input of a dietician in their care. The dietician participated in the multidisciplinary ward round, where feeding regimes were reviewed and adapted to reflect individual needs.
- Speech and language therapists were available for swallowing assessments as required.

### Nutrition and hydration

- Staff had carried out a number of mandatory local, regional and national audits to monitor the effectiveness of the service. They participated in the Intensive Care National Audit and Research Centre audit (ICNARC). (ICNARC collects data from participating critical care units, such as average occupancy, death rates and number of patients re-admitted to the unit within 48 hours of transfer.)

# Critical care

- The ICNARC data for 2013 showed that outcomes compared well with national comparators. There were no areas where the trust was an outlier.
- Monthly morbidity and mortality meetings were held. There were no mortality outliers at the time of our inspection.

### Patient outcomes

- Staff had carried out a number of mandatory local, regional and national audits to monitor the effectiveness of the service. They participated in the Intensive Care National Audit and Research Centre (ICNARC) audits. ICNARC collects data from participating critical care units, such as average occupancy, death rates and readmission of patients to the unit within 48 hours of transfer.
- The ICNARC data for 2013 showed outcomes compared well to national comparators.

### Competent staff

- All staff had an annual appraisal when individual objectives were agreed and progress discussed.
- Staff told us they were satisfied with the internal and external learning and development opportunities provided, and that they attended regular one-to-one meetings with their line manager as well as the unit's staff meetings.
- Medical and nursing staff had been allocated specific responsibilities to act as lead links to or to champion in some specialist areas. However, no eligibility criteria or job descriptions were attached to the roles, and staff told us they had not been provided with any specific training other than the trust's mandatory training in areas such as infection prevention and control. There were no formal meetings between the link nurses and specialist nurses in most specialties.
- Newly appointed staff undertook an induction programme and were allocated a period of six to eight weeks' supernumerary practice.
- Among nursing staff, 71% held a post-registration award in critical care nursing – a percentage that was above the required standard of 50%.
- All foundation year doctors were supernumery while on the unit. Registrars were all competent to carry out duties on the unit after undergoing the units own induction programme.
- The unit employed a practice development nurse who provided ward based teaching for staff.

### Multidisciplinary working

- There was a daily ward round to review patients' needs, with input from the multidisciplinary team (MDT) members, including doctors, nurses, physiotherapists, a pharmacist, dietician and managers.
- We saw evidence of referrals to other professionals such as the drug and alcohol service, organ donation specialist, tissue viability nurse and learning disability team. Referrals were acted upon in a timely and effective way and all interventions documented in the patient's records.
- MDT members who did not attend daily ward rounds, such as the microbiologist and speech and language therapist, had a verbal handover every time they visited the unit, and also recorded their interventions in patients' notes. In addition the Microbiologist received a daily written handover by e-mail
- All staff reported that the unit provided effective care and that there were no problems with accessing support and advice from the MDT out of hours.
- A member of the rapid response team visited all patients following their discharge from the unit.

### Seven-day services

- Staff and patients spoke positively about the seven day-services available. Records confirmed that effective arrangements were in place.
- Imaging (X-ray and scans), physiotherapy and occupational therapy support was available seven days a week.
- The pharmacist or pharmacy technician visited the department every week day to manage the stock and advise staff. The pharmacy was open on Saturday and Sunday mornings. Outside these times senior nursing staff were able to access a defined stock of medicines.

## Are critical care services caring?

Good

From the data reviewed, our observations and our conversations with staff, patients and relatives, we judged the service in the unit to be caring. Patients and those close to them regarded staff as approachable and kind, and were very satisfied with the level of care provided.

The care plans, patients' records, and risk assessments we looked at were up to date and individual in describing each

patient's needs. We saw good examples of personalised care and emotional support being provided by staff from different professions. Patients and those close to them told us they were very satisfied with the care provided. Staff told us they were satisfied with the level of care they were able to provide.

### Compassionate care

- We observed patients being treated in a kind and caring way.
- We saw that curtains were drawn around bed spaces to ensure privacy when treatment and personal care were delivered and staff ensured confidentiality when speaking to people at the nurses' station or on the telephone.
- There were numerous thank you cards from patients or relatives thanking staff for looking after them.
- Without exception, patients and relatives that we spoke with told us they had been looked after well by all of the team in the unit.
- We noted that patients who were unconscious were communicated with by the nursing and medical staff. For example, they explained to the patient what they were doing.

### Patient understanding and involvement

- Patients and those close to them told us they felt involved in patients' care.
- We noted that care plans and based on the individual needs of the patient, and risk assessments were personalised.
- All patients and relatives we spoke with told us they had been kept fully informed and had sufficient opportunities to have their questions answered.

### Emotional support

- During our visit we saw doctors, nurses and a range of other healthcare professionals actively involved in supporting people's emotional needs.
- On arrival to the unit, patients and relatives received an information booklet which contained information about what to expect in the first few days of admission to critical care.
- We saw that patients were referred to other specialist services for support and counselling for alcohol addiction.
- Staff made people aware of relevant support groups and services, such as the multi-faith chaplaincy service and the follow-up support for patients and relatives. These services had been positively evaluated by patients.
- Patients' spiritual needs were assessed and acted upon, with (multi-faith) support provided by the chaplaincy service. The chaplaincy made daily visits onto the unit.
- Relatives and patients told us they felt supported and cared for in the unit.
- The unit was very involved with a national charity called ICU Steps. This started in Milton Keynes hospital in 2006 and is now a nationally recognised charity supporting patients and relatives as well as other hospitals to set up patient and relatives support groups.
- Emotional support was also available for staff, patients and families from a clinical psychologist.
- All patients and their relatives who were ventilated on the unit for 4 days or more were given the opportunity to return to be reviewed by a consultant anaesthetist and a senior sister. A physical and psychological assessment with time to answer questions and worries took place. There was also an opportunity for patients to look round the unit and meet with the staff that cared for them.
- A patients and relative support group was run by the senior sister as well as ex patients and relatives. Patients and relatives could get support from other peoples who understood their experiences of being in a critical care unit.

## Are critical care services responsive?

Good

From the data reviewed, our observations and the conversations we had with staff, patients and relatives, we judged the service in the unit to be responsive. Patients' needs were assessed and acted upon in a timely and responsive way. Staff provided individualised care and treatment. Staff in the service understood and met the different needs of the community.

Bed occupancy was generally around the England average, although there had been three occasions when it had risen above the average. Patients were not usually transferred

from the unit out of hours. However, there were occasional problems with delayed discharges of people, which had been escalated and managed in accordance with trust's policies.

The Department of Critical Care (DOCC) encouraged patients, relatives and staff to provide feedback about their experiences, and this Information was shared and acted upon.

### Service planning and delivery to meet the needs of local people

- People were referred to the service according to clinical need after a comprehensive assessment.
- The organisation of services was responsive to the needs of local people. The service worked collaboratively with other services such as general practitioners, and other teams within the hospital.
- The entrance and waiting area for visitors was separate from the unit and entry was controlled by staff.
- There was a relatives' room with a supply of refreshments, information, and a bathroom. Relatives told us they welcomed the facilities. However we saw the relatives' bathroom was also being used by a patient as the bathroom on the unit was out of order.
- People close to the patients were encouraged to visit. Visiting hours were between 10.30 hours and 20 00 hours with a period of rest and quiet time allocated between 13.30 hours and 15.00 hours. There were effective arrangements for flexible visiting when required.
- Staff working in unit were part of the Thames Valley and Wessex Critical Care Network. This meant patients could be transferred to other specialist units as required.
- There was a process in place to transfer patients and consultants took responsibility to speak with the receiving consultant to give a handover. Telephone nurse to nurse handover also took place.
- The unit followed the critical care networks transfer protocol and a transfer form was completed.
- Depending on the dependency of the patient, a nurse or a nurse and anaesthetic doctor would escort the patient.
- There were specific arrangements in place for the transfer of children to other critical care units.
- No bed bookings for elective surgical critical care had been cancelled because of lack of beds.

### Access and flow

- Information provided by the trust showed that average bed occupancy was generally in line with the National average occupancy rate for England, using the ICNARC 2012/2013 indicators.
- All decisions to admit patients were agreed by the Consultant. A recent audit showed that between June 2014 and august 2014 the average time from decision to admit to the actual admission was 2 hours and 12 minutes. The national standard was to admit patient within 4 hours of referral.
- One person we spoke with experienced a delayed transfer to the ward. They told us they were satisfied with this option as they trusted the doctors and nurses, described them as caring, and felt engaged in discussions and decisions about treatment and care. There was another delayed discharge identified as a risk on the risk register in September 2014.
- Staff told us that discharges did not always take place within 07.00 and 22.00 hours. The trust monitored this and we saw between November 2013 and September 2014, 9.7% of patients were transferred out of the unit between 22.00hrs and 07.00hrs.
- Discharge and delayed discharges were monitored by the trust. Between November 2013 and September 2014 there had been 212 hours where patients were waiting to be discharged from the unit. Delays were primarily due to pressure on beds within the rest of the hospital.
- ICNARC data showed that the trust was about the same as other units for non-clinical transfers out; better than other units for out of hours discharges to the ward and for out of hours discharges not being delayed.

### Meeting people's individual needs

- The physiotherapy service for critical care met the core standards relating to the assessment and treatment of patients in the unit. However, the core standard or National Institute for Health and Care Excellence (NICE) guidance to have processes in place to ensure that the rehabilitation needs of all people are assessed within 24 hours was not being met. Managers were aware of the need for this and showed us that plans were in place to implement processes in December 2014.
- We saw that an augmentitive & alternative communication device (letter board to communicate with people who are unable to speak) was used to allow a patient to communicate their wants and needs with good effect.

- We observed clinical staff were accessible and responded to patient's call bells immediately.
- Interpreter services were available for people who required them. There was a trust wide policy for interpreting services in place but the policy we looked at had passed the stated review date of 2012. Information leaflets were available in different languages.
- Patients told us they were comfortable and we saw evidence that people were repositioned in accordance with their care plan and skin bundle. We saw staff supporting patients with complex needs through collaborative working with specialist nurses who visited the patient daily and ensured care plans were kept up to date.
- There was a flexible admission policy. We saw examples of people coming in from the community to have their tracheostomy (breathing tube) changed and for advice relating to their on-going care needs.

### Learning from complaints and concerns

- Between January 2014 and December 2014 the department had one complaint. In addition, the department had been asked to respond to two further formal complaints indirectly as the department had formed part of the patient pathway. These had all been handled in accordance with the trust's policy. Between April 2014 and June 2014 they had received14 formal compliments.
- Complaints were recorded as incidents on the trusts patient safety reporting system.
- Learning from complaints and concerns was shared, including at handover reports, unit staff meetings, and monthly clinical improvement group meetings. Learning was also clearly recorded in minutes and displayed on noticeboards.
- Information about the comments and compliments the unit had received were on display for staff and patients or relatives.
- The complaints process was clearly displayed in public areas and we found it was understood by patients, relatives and staff.
- Complaints were recorded through the trusts incident reporting system. Learning from complaints and concerns was shared at forums including handover reports, unit staff meetings, and monthly Clinical Improvement Group meetings. Learning was also clearly recorded in minutes and displayed on notice boards.
- We saw the learning from a specific complaint had brought about a change in practice. It had resulted in an increase in the nursing staffing establishment.

## Are critical care services well-led?

Good

A range of systems and meetings were in place to monitor and review the service. Quality monitoring took place to monitor the service being provided. A risk register was in place which was reviewed risks were mitigated against.

Managers described the clinical leadership within the department as "dynamic, enthusiastic and patient focused". Doctors felt well support by consultant medical staff. Nurses were well led and there was a sense of team working in the unit. The unit was heavily involved with the work of the ICU Steps national charity which had been formed at Milton Keynes Hospital. There was good patient and staff engagement and a commitment by everyone to give the best possible care to patients requiring critical care.

### Vision and strategy for this service

- A vision and strategy was in place for the unit. Staff were able to tell us about the "We care" programme which were the trusts values.
- Staff told us that the department met formally on a monthly basis to review its strategy.

### Governance, risk management and quality measurement

- A range of systems and meetings were in place to monitor and review the service. Records of the meetings showed they were well attended by doctors, nurses, the rapid response team and operating department practitioners, and that staff reviewed guidelines and pathways.
- Audits were carried out and actions arising from them completed, for example regarding the safe and secure handling of medicines.
- A risk register was in place which showed risks were identified and managed.

### Leadership of service

- Managers described the clinical leadership within the department as "dynamic, enthusiastic and patient focused".

# Critical care

- Trainee doctors told us they felt well supported by consultants, who were always available.
- Staff described management in the day and at night as good, and told us there was a nightly management meeting with the medical consultant.
- Clinical staff at all levels felt involved in the redesign of services. They also spoke positively of the involvement of clinical managers and the chief executive officer, and of their response to patients' clinical needs.
- Nursing staff and medical staff told us they had an excellent relationship and that they felt comfortable challenging each other's practice if necessary.
- The matron's role had changed within the past year to include management of the operating department (theatres). However, staff told us there was no negative impact, because the matron was accessible at all times and attended the unit at least daily. Email and telephone communication was described as good by staff.

### Culture within the service

- All the staff we spoke with felt positively about the culture within the unit, describing it as supportive. They also referred to the smooth running of the department.
- All the staff we spoke with felt supported in their learning and development, and described the management teams in the unit and the trust as dynamic and willing to change.
- Staff worked well together and showed obvious respect for their colleagues. Staff reported that communication between nurses and doctors was open and that relationships had improved significantly after junior doctors in training raised some concerns in 2012.
- Staff sickness rates were low (below 2%). Staff described the support from occupational health department as good and spoke positively of the phased return to work, when implemented.
- Several members of staff had been shortlisted for or won national awards for their work within the critical care unit.

### Public and staff engagement

- The trust used the Friends and Family test. However, staff told us this was not tailored for critical care and no data was available for the unit.
- Staff and patients spoke positively about the systems in place for patients to feed back their experiences.
- Of the 30 staff who completed a recent staff survey, 28 said they felt respected, valued and supported; only two said they did not.
- All clinical staff said they felt able to voice their opinions and that they were listened to by senior staff; however, not all the managers we spoke with were able to describe the results or impact of the staff survey.
- There was excellent public/patient engagement within the service. This was led through the charity ICU Steps that had close links with Milton Keynes Hospital. The team were rightly proud of this work. The unit's senior sister was the chair of the charity and several ex patients of the Milton Keynes unit were trustees. The charity had been involved as patient representatives on numerous trials such as a sepsis trial at imperial College Hospital, London, a nutritional study in conjunction with ICNARC and a study on the effect of statins in reducing ICU delirium.

### Innovation, improvement and sustainability

- Nursing and medical staff actively engaged with the Thames Valley and Wessex Critical Care Network. (This local network includes NHS and independent providers of critical care services within the region. The members of the network share learning, experiences and innovation for the benefit of patients and staff.) Staff told us they were encouraged and supported by the trust to participate in the network, and demonstrated regular attendance at local and national network meetings designed to share good practice.

# Maternity and gynaecology

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

The trust's maternity and family planning services at Milton Keynes Hospital provided antenatal, intrapartum and postnatal care to patients. The service also included a delivery theatre and provided community based midwifery services. The maternity service included a neonatal unit and we have reported on this area in the children and young people section of this report. There were more than 3800 deliveries every year at the unit.

During our inspection we visited Labour Ward, Wards 9 and 10, the antenatal clinics, Early Pregnancy Assessment Unit and Surgical Assessment Unit. We spoke with patients, relatives and staff within the service. We observed care and treatment and looked at care records. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust's maternity service.

## Summary of findings

The trust provided good maternity and gynaecology services.

The maternity service had been significant challenges in the previous 12-18 months. Whistle blowing, a trend in incidents and a number of neonatal deaths had placed the service under enhanced scrutiny. There had been some significant changes in the leadership of the service over the past 6-12 months and the trust had implemented additional systems to monitor the quality being provided.

The maternity service used Birth-rate Plus to monitor its midwifery staffing workforce. Birth-rate plus is a tool used to calculate the staffing levels required in a service. Staffing was reviewed every six months. The maternity service had a ratio of midwives to births of 1:30.

The trust incident reporting system was used throughout maternity and gynaecology services. We saw evidence that some incidents had been discussed at maternity service clinical governance and team meetings.

We saw evidence of effective on-going assessment of clinical needs and risks throughout pregnancy and childbirth for women treated within maternity services.

The vast majority of women we spoke with told us they had received good, compassionate care from staff in the maternity service. Staff also maintained women's dignity throughout the delivery of their care.

# Maternity and gynaecology

The trust's maternity service did not have a separate midwife-led unit. The directorate had taken some action in trying to provide limited provision of midwife-led care, but this had not been fully completed at the time of our inspection. Most obstetric care provided by the trust remained consultant led. Women were able to choose their preferred place of birth, 2% of women chose to have a home birth.

We found, however, that women could not directly access services from the Early Pregnancy Assessment Unit (EPAU), and had to be referred by their GP or midwife, if they had one. This meant that women were not always able to access care from the EPAU in the most efficient and timely way.

The trust's maternity service had a dedicated obstetric theatre and an additional theatre on standby if this was also required. After a baby had been delivered in the obstetric theatre, the mother and baby were usually not cared for together in the theatre recovery area. The trust's maternity service enabled partners to stay overnight on Ward 9 after their baby had been delivered.

Translation services or translators were readily available and easily accessible for women whose first language was not English.

Complaints were handled in line with the trust's policy. Staff were encouraged to resolve issues, concerns and complaints reported by people at a local level.

Gynaecology patients within the trust did not have a dedicated gynaecology ward to which they were admitted. This meant gynaecology patients were located on different, non-adjacent wards in the hospital. We did not find evidence that suggested the outcomes of these women were affected by this, but staff felt the profile of gynaecology services had been reduced.

The directorate service specific strategy and vision was to put 'patient safety first.' Staff told us senior management were available and visible to staff. A new divisional management team for Women's and Children's was created on 1st April 2014. This team was actively working to develop and establish a culture of openness, transparency and learning within the directorate.

## Are maternity and gynaecology services safe?

Good

The maternity service used Birth-rate Plus to monitor its midwifery staffing workforce. Birth-rate plus is a tool used to calculate the staffing levels required in a service. Staffing was reviewed every six months.

The trust's incident reporting system was used throughout the maternity and gynaecology services. We saw evidence that incidents had been discussed at clinical governance and team meetings.

The wards and clinic areas all appeared clean.

Medicines were stored correctly in locked cupboards or fridges where necessary, and controlled drugs were stored in separate locked cupboards. However, the maternity services did not have an identified pharmacist allocated to support their wards and teams with regard to medicines management and audit.

### Incidents

- The trust's incident reporting system was used throughout the maternity and gynaecology services. Staff were aware of the system and used it to report incidents. Staff we spoke with told us they felt encouraged and supported to report incidents.
- The directorate's management team confirmed that reported incidents were regularly reviewed so that learning from incidents could be shared within the services. Actions had been implemented to improve practice and learn from incidents.
- We saw evidence that some incidents had been discussed at maternity service clinical governance and team meetings. Staff told us they received feedback about some of the reported incidents.
- There had been two reported never events in the maternity service in the last two years, both of which related to retained tampons or swabs. Never events are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented.
- The directorate's management team confirmed that the maternity service held regular mortality and morbidity meetings.

# Maternity and gynaecology

### Safety thermometer

- Safety information posters had recently been displayed within each ward. They included information about staffing levels, incidents and compliance with risk assessments. The service was performing within expectations.

### Cleanliness, infection control and hygiene

- We checked ward and clinic areas within the maternity service for cleanliness. We found that patients' bays, beds and equipment were clean.
- We found that hand gel dispensers were situated in clinical and public areas, including the entrances to wards and clinics.
- We saw staff members using hand gels regularly and routinely during their work.
- There were no recently reported cases of methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile. Infection rates were well controlled and rates for the maternity services were within expected limits.
- We spoke with domestic staff who were allocated to and worked within specific wards or areas of the maternity service. They told us that their managers routinely completed cleaning audits. We saw that audit results were displayed on ward safety information posters. The cleaning audit results in maternity services were within required performance expectations.

### Environment and equipment

- A security access system was in place that managed access to wards and clinics during the day and night. This system ensured that staff, patients and visitors had safe access to clinical areas, managed in line with local and trust-wide security requirements.
- There was adequate equipment on the wards to ensure safe delivery of care. Sealed resuscitation equipment boxes were supplied to individual wards and clinics by the trust resuscitation team, in line with the trust's policy.
- Although staff did not open resuscitation boxes unless the equipment was required, staff we spoke with told us they received training and information about the resuscitation boxes and their contents at directorate training days.
- We checked resuscitation trolleys and equipment on wards and within individual rooms and patient bays. These were adequately stocked. However, we found that daily audit checks of the trolleys and equipment had not always been completed in line with the directorate's schedule. We discussed this with ward managers and matrons, who acknowledged that checks had not always been completed.

### Medicines

- Medicines were stored correctly in locked cupboards or fridges where necessary, and controlled drugs were stored in separate locked cupboards. This meant that medicines were stored securely.
- Fridge temperatures were routinely checked to ensure that medicines were stored within the required temperature ranges. We checked medicines records. We found that these were mostly completed and were in line with the trust's policy.
- We noted that some medicines records showed that only one member of staff had signed for the administration of medicines when two staff members were required to do so. We also found that some entries had not been accurately completed with full details of the patient or the medicines administered.
- We discussed these discrepancies with the relevant ward managers, who confirmed that daily and weekly audits should have been completed to monitor the administration of medicines. Following this discussion, we noted that the ward managers had taken action straight away and the issues had been discussed at staff handover meetings.
- There was no dedicated pharmacy support for the maternity service.

### Records

- We looked at seven care plans in total during our inspection and found that staff had assessed patients' individual needs and documented information relevant to their care.
- We found that records were accessible but not always well filed. Therefore it was sometimes difficult to follow individual notes for women receiving care.
- We saw that records were stored securely.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of the Mental Capacity Act 2005 and Depravation of Liberty Safeguards.
- At the time of our inspection there no women affected by Deprivation of Liberty Safeguards within the service.

# Maternity and gynaecology

## Safeguarding

- We spoke with the trust's safeguarding lead about safeguarding within the maternity service. We found that safeguarding procedures were in place and were effective.
- Midwifery staff told us they were encouraged to raise and report any actual or potential safeguarding concerns.

## Mandatory training

- We noted that staff had attended relevant mandatory training, including on infection control and conflict resolution.

## Management of deteriorating patients

- Maternal early warning scores were used within the maternity services. This meant that patients were assessed to ensure that appropriate and timely care was delivered.
- The maternity service used the 'five steps to safer surgery' checklist when surgery was undertaken. This meant that checks were completed to ensure that the right procedures were completed for each patient.

## Midwifery staffing

- The maternity service used Birth-rate Plus to monitor its midwifery staffing workforce. Birth-rate plus is a tool used to calculate the staffing levels required in a service. Staffing was reviewed every six months. The is no national recommended ratio for midwives to births. The maternity service had a ratio of midwives to births of 1:30.
- We noted that only the clinical elements of specialist midwives and those at band 7 or above were counted within the staffing workforce.
- Staff stated that bank and agency staff were used to cover gaps in rotas. Staff told us that, wherever possible, regular bank or agency staff were used to provide greater continuity of patient care.
- We found that community midwifery caseloads were higher than expected. New staff had been recruited to join the community midwifery team, but these staff had not yet started work.
- We also noted that the ratio of supervisors of midwives to midwives was 1:19, which was worse than the national standard of 1:15. We were told there were only nine supervisors of midwives at the time when our inspection was completed, but that more midwives were in training to take up these roles.
- We observed two midwifery handovers. We found that key information relating to patients was shared, along with ward and directorate information, to keep staff updated.

## Medical staffing

- Maternity and gynaecology services had 60 hours a week of dedicated consultant cover. This was in line with national recommendations for the number of babies delivered at the trust per annum.
- The maternity service used locum consultants, but these staff members had worked within the service for a long time and new the hospital well.
- We noted that five out of nine middle grade staff posts were vacant at the time of our inspection. The directorate's management team confirmed that recruitment was ongoing and the vacancies were being covered internally.
- We observed one medical handover and found that information was discussed and shared to enable medical staff to provide safe care and treatment.
- The shortage of middle grade staff meant that there was sometimes a member of the on call team missing and thus the on call consultant had to cover all the inpatient gynaecological patients and the gynaecological emergencies with an FY1/2 doctor whilst covering the maternity unit

## Neo-natal deaths between July 2013 and March 2014

- The Trust confirmed there had been five neonatal deaths between July 2013 and March 2014. These had been investigated internally. Following the trust's internal review, the trust commissioned further external independent reviews into the deaths; one external review looked at the five perinatal deaths and the Royal College of Obstetricians and Gynaecologists (RCOG)and the Royal College of Midwives (RCM) undertook a more wide ranging review into the service.The RCOG and RCM report had not been published when the CQC inspection was undertaken.
- The trust confirmed that significant investment had been made in the maternity service following its internal review of the neonatal deaths. This included providing new cardiotocograph monitoring for intrapartum care.
- .Learning from the trust's internal review had been developed. An independent, external senior clinician

was supporting the maternity service and its staff to recognise, develop and implement changes aimed at improving the safe provision of care by the trust's maternity service.
- The trust engaged with the families affected by the neonatal deaths, and staff were also kept updated. The trust had fully committed to publishing reports and reviewing findings throughout the process.

## Are maternity and gynaecology services effective?

Good

We saw evidence of effective on-going assessment of clinical needs and risks throughout pregnancy and childbirth for women treated within maternity services.

We saw that appropriate guidelines were in date and review dates were clearly stipulated, which meant maternity service staff were assured they were following up-to-date national guidelines. Guidelines were also easy for staff to access them in a timely manner.

We noted that a good antenatal system was in place which ensured the appropriate pathway was selected for individual women.

We spoke with staff in clinical and non-clinical roles from various wards and departments within the maternity service. We found that individuals and teams generally worked well together to deliver care that met the needs of women.

### Evidence-based care and treatment

- The maternity service used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines to determine the treatment and care provided.
- We saw that appropriate guidelines were in date and review dates were clearly stipulated, which meant maternity service staff were assured they were following up-to-date national guidelines. Guidelines were also easy for staff to access them in a timely manner.
- Maternity services were compliant with antenatal screening requirements.
- We found that audit plans and processes were not effectively completed. We noted that the trust's maternity service failed to meet all five of the standards from the National Neonatal Audit Programme 2012. The trust had responded to this and had implemented new processes, including a new parent communication sheet. The trust felt some of the failure with this audit was due to inadequate data input and they had worked on this to make improvements. The latest NNAP data showed significant improvements.

### Pain relief

- We found that pain relief was available in an appropriate and timely manner. Epidurals were all given within 30 minutes of being requested, which meant pain relief was provided to meet the needs of women.

### Patient outcomes

- Staff and managers monitored, reviewed and regularly reported on key guideline performance indicators. Maternity service dashboards were produced monthly and circulated to all clinical areas and the trust's executive team.
- The dashboard key performance indicators included midwifery and obstetrician staffing levels, number of complaints and number of readmissions following elective and non-elective admissions. This showed on-going assessment of the maternity service's performance in relation to key indicators of clinical care.
- We saw evidence of on-going assessment of clinical needs and risks throughout pregnancy and childbirth for women treated within the maternity services.
- The CQC routinely monitors patient outlier information for the trust, including maternity outlier alerts. The CQC maternity outlier surveillance programme reviews indicators for effectiveness, which includes maternal readmissions, perinatal mortality, emergency caesarean sections and elective caesarean sections.
- At the time of our inspection, there were no outstanding maternity outlier alerts reported for the trust's maternity service and no evidence of risk.
- The modes of delivery of babies in the trust were in line with national averages for England.
- We noted that a good antenatal system was in place which ensured the appropriate pathway was selected for individual women.

# Maternity and gynaecology

### Competent staff

- We looked at the records of staff mandatory training, including training for infection control, information governance and safeguarding of adults and children. Records confirmed that most staff were up to date with their mandatory training.
- Staff we spoke with told us they received appraisals. We saw 94% of midwifery appraisals had been completed.
- Staff told us they felt able to discuss issues with their line managers as required, not just when they completed their appraisals.
- Medical staff also received appraisals; around 70% of these appraisals had been completed at the time of our inspection and were on target to have completed 100% by the end of the financial year.

### Multidisciplinary working

- We spoke with staff in clinical and non-clinical roles from various wards and departments within the maternity service. We found that individuals and teams generally worked well together to deliver care that met the needs of women.

### Seven-day services

- Staff told us they had access to on-call staff including consultants and the lead midwife. This meant appropriately skilled staff were available to provide advice, guidance and treatment out of hours.

## Are maternity and gynaecology services caring?

Good

The vast majority of women we spoke with told us they had received good, compassionate care from staff in the maternity service. Staff also maintained women's dignity throughout the delivery of their care.

Partners were able to stay and provide support, which meant they were involved in the care offered to patients.

The maternity service had a specialist bereavement midwife who had recently won a national award for her work in the trust's maternity service.

### Compassionate care

- We observed women being treated with compassion, dignity and respect in all areas of the trust's maternity service. We found that staff welcomed women and remained respectful and professional during the delivery of care.
- We saw that staff completed system of visits to women and their babies which they called "intentional rounding" This system was intended to check on mothers and their babies in a regular and timely way.
- The vast majority of women we spoke with told us they had received good, compassionate care from staff in the maternity service.
- We witnessed staff maintain the confidentiality of individual women were treated with privacy and any concerns about confidentiality were addressed by staff.
- Staff maintained women's dignity throughout the delivery of their care.
- In the CQC's survey of women's experiences of maternity services in 2013, the trust's maternity service scored 9.1 out of 10 for women saying that they had been treated with respect and dignity during their labour and the birth of their baby.
- The results of the Friends and Family test for the trust's maternity service were better than national averages.

### Patient understanding and involvement

- Partners were able to stay and provide support, which meant they were involved in the care offered to patients.
- In the CQC's survey of women's experiences of maternity services, 2013, the trust scored 9.5 out of 10 for women expressing that their partners or people close to them were involved as much as they wanted to be during labour and the birth of the baby.
- We saw in patients' notes that women were involved in planning their own care. This meant that staff listened to and acknowledged the wishes of individual women when planning their care.

### Emotional support

- The maternity service had a specialist bereavement midwife. This midwife had been instrumental in arranging appropriate bereavement support and ensuring that facilities and processes were in place to support bereaved mothers and families.
- The bereavement midwife had also liaised with mothers and families and local organisations outside the trust to

have a garden of remembrance built and landscaped within the trust's premises. The garden was established specifically to meet the emotional needs of bereaved families and staff.

- The bereavement specialist midwife had recently won a national award for her work in the trust's maternity service. A bereaved mother who had been supported by the specialist midwife nominated her for the award.

## Are maternity and gynaecology services responsive?

Good

The trust's maternity service did not have a separate midwife-led unit. The directorate had taken some action in trying to provide limited provision of midwife-led care, but this had not been fully completed at the time of our inspection. Most obstetric care provided by the trust remained consultant led. Women were able to choose their preferred place of birth, 2% of women chose to have a home birth.

We found, however, that women could not directly access services from the Early Pregnancy Assessment Unit (EPAU), and had to be referred by their GP or midwife, if they had one. This meant that women were not always able to access care from the EPAU in the most efficient and timely way.

The trust's maternity service had a dedicated obstetric theatre and an additional theatre on standby if this was also required. After a baby had been delivered in the obstetric theatre, the mother and baby were usually not cared for together in the theatre recovery area. The trust's maternity service enabled partners to stay overnight on Ward 9 after their baby had been delivered.

Translation services or translators were readily available and easily accessible for women whose first language was not English.

Complaints were handled in line with the trust's policy. Staff were encouraged to resolve issues, concerns and complaints reported by people at a local level.

Gynaecology patients within the trust did not have a dedicated gynaecology ward to which they were admitted. This meant gynaecology patients were located on different, non-adjacent wards in the hospital. We did not find any evidence that outcomes for patients were affected by this, but the trust recognised having a dedicated area for gynaecology patients would be preferable. There were long term plans for a dedicated women's unit within the hospital.

### Service planning and delivery to meet the needs of local people

- The trust's maternity bereavement service had clear processes in place that provided supportive care to women and their families who had suffered a bereavement.
- The trust's maternity service did not have a separate midwife-led unit. The directorate had taken some action in trying to provide limited provision of midwife-led care, but this had not been fully completed at the time of our inspection. Most obstetric care provided by the trust remained consultant led.
- The partners of women who had given birth were able to stay overnight on Ward 9 after their baby had been delivered. This meant women were able to have their partners remain with them for support.
- However, partners staying overnight meant access to women and equipment in their bed area, especially for women receiving care in a four-bedded bay, was sometimes cramped for both staff and women.
- There had been no consultation with the trust's health and safety or fire teams to establish operational protocols for partners who remained on Ward 9 overnight.
- The ward clerk role on Ward 9 is full time covering 12 hours per day. At times when the ward clerk was not present on the ward, midwives and maternity support workers had to manage access on and off the ward. This meant that midwives and maternity support workers were taken away from direct delivery of care to operate the access-control system for the ward. We noted significant delays when attempting to access the ward as there was no-one answering the call bell.
- Women were able to choose their preferred place of birth. Of women receiving care from the maternity service, 2% chose to have their baby at home.

# Maternity and gynaecology

### Access and flow

- Women who needed care and treatment from the maternity services could access such treatment through a variety of routes. These included direct access to services through community midwives and the labour ward.
- We found, however, that women could not directly access services from the Early Pregnancy Assessment Unit (EPAU), and had to be referred by their GP or midwife, if they had one. This meant that women were not always able to access care from the EPAU in the most efficient and timely way.
- The trust's maternity service had a dedicated obstetric theatre and an additional theatre on standby if this was also required.
- After a baby had been delivered in the obstetric theatre, the mother and baby were usually not cared for together in the theatre recovery area. Mothers remained in the theatre recovery area while babies returned to the wards. This meant the maternity service was not always responsive to women's individual care needs and wishes.
- Staff told us that the procedure for induction of labour was not always responsive to the needs of women. Staff confirmed that women who were due to have an induction of labour called the ward at 8am but they may be advised to call back at 11am because there may be no physical capacity available until 11am. However, this would not cause a delay in their induction. The trust were aware of this and they were in the process of reviewing their induction guidelines and considering a new approach to delivering this care to women.
- The maternity service confirmed that it had been closed on three occasions between April and September 2014. The closures were due to increased activity and the reasons were reviewed in conjunction with the commissioners of the service.
- There was no dedicated gynaecology ward at Milton Keynes Hospital. This was because the number of inpatients was small. Elective gynaecology patients were cared for as part of the planned care pathways within the general surgical wards and departments. Patients requiring emergency pathways were cared for on various surgical ward areas. Gynaecologists oversaw their care.
- Consultants and other medical staff who were responsible for the assessment, care and treatment of gynaecology patients had to identify on which ward they were admitted before the patients could be seen.
- We did not find any evidence that outcomes for patients were affected by this, but the trust recognised having a dedicated area for gynaecology patients would be preferable. There were long term plans for a dedicated women's unit within the hospital.

### Meeting people's individual needs

- Translation services or translators were readily available and easily accessible for women whose first language was not English. This was the case for women accessing care and treatment in both hospital and community settings.
- Specialist midwives and antenatal care was available for specific groups of women, including women who might be vulnerable or had particular care needs.
- We saw first-hand how the team cared for a woman with specific needs and was vulnerable. They demonstrated a very caring and sensitive approach to her care.
- We noted there was limited provision of gynaecology oncology specialist nurse support

### Learning from complaints and concerns

- Complaints were handled in line with the trust's policy.
- Staff were encouraged to resolve issues, concerns and complaints reported by people at a local level. If this action did not adequately resolve the person's concerns, the concerns were reported to managers at local and directorate levels for further resolution.
- Leaflets containing information about the Patient Advice and Liaison Service (PALS) and the trust's complaints process were readily available in maternity services areas. Information was also available on the trust's website and from individual staff. This meant the service provided relevant information and access to PALS and complaints teams in order to address, resolve and respond to people's concerns.

### Are maternity and gynaecology services well-led?

Good

# Maternity and gynaecology

The trust's vision was displayed in the maternity and gynaecology services. The directorate's service-specific strategy and vision was "to put patient safety first".

Staff told us that senior management, including ward and directorate managers, were available and visible to staff. Most staff said they felt supported by their local and directorate management teams.

A new directorate management team had been created within the last year for maternity and gynaecology services. This team was actively working to develop and establish a culture of openness, transparency and learning within the directorate.

The trust's maternity and gynaecology services had clear management and governance structures in place within the obstetrics and gynaecology specialties. However, we found some delays in the management of maternity- and gynaecology-related governance procedures.

## Vision and strategy for this service

- The trust's vision was displayed in the maternity and gynaecology services. The directorate's service-specific strategy and vision was to "put patient safety first".
- Although staff in maternity services were aware of the principles of the trust and of the directorate's vision, they were not always able to articulate the vision statements.
- Throughout our inspection we saw that maternity and gynaecology services staff provided care in accordance with the trust's and the directorate's visions.

## Governance, risk management and quality measurement

- The trust's maternity and gynaecology services had clear management and governance structures in place within the obstetrics and gynaecology specialties. Staff roles and lines of management were evident for clinical and non-clinical staff throughout the directorates.
- The maternity service used a quality dashboard to record, monitor, manage and review key indicators of clinical performance. Indicators included reported incidents, audits undertaken and complaints received by the service. This meant there was an on-going review and assessment of key performance indicators for the directorate and its specialties.
- The directorate's senior managers had identified key risks that were communicated by operational staff working in the community and in outpatient clinical areas.
- We found some delays in the management of some governance procedures. The directorate's governance team had not always monitored, updated or checked for the completion of action plans that had resulted from serious incident investigations or root cause analysis. This meant there was the potential for missed opportunities to learn and prevent further incidents.
- The maternity service had a risk register in place. The risk were discussed at the departmental clinical governance groups which were monthly. All risks that were cored as 12 or above were escalated to the divisional risk register which was discussed at monthly clinical improvement group meetings. All risks of 15 and above were then escalated to the trusts wide significant risk register which is discussed at the monthly risk and compliance board. We saw mitigating actions were in place for all of the risks on the various registers.

## Leadership of service

- Staff told us that senior management, including ward and directorate managers, were available and visible to staff. Most staff said they felt supported by their local and directorate management teams.
- Most staff knew who the trust's chief executive office was; however, other staff told us that members of the executive team had not visited the directorate's wards until recently.
- Staff in community maternity services told us that senior management personnel in the directorate and trust were less visible within community services than in the inpatient hospital services.

## Culture within the service

- A new divisional management team for Women's and Children's was created on 1st April 2014. This team was actively working to establish a culture of openness, transparency and learning within the directorate.
- Staff told us the new team were very visible and responded actively and enthusiastically to staff suggestions.
- Staff who worked in the maternity services were proud of the care delivered to people and proud that they worked at the trust. Staff worked well together.
- Maternity specialty staff felt their profile had been raised within the trust and with the executive team. This was in

part because of the two Never Events and five neonatal deaths in the last two years. However, staff felt it was valuable for the maternity specialty to be an increasingly high profile specialty within the trust.
- In contrast, the gynaecology specialty staff we spoke with told us they felt the profile of their specialty was minimal within both the trust and the executive team.

### Public and staff engagement

- Matrons held weekly ward rounds and were required to speak with at least two women about their experiences of their care.
- A listening event was held to obtain feedback from women.
- There was a patient forum in place with representatives who had experienced the maternity service.

### Innovation, improvement and sustainability

- The directorate's senior managers confirmed that an on-going recruitment programme was in place for midwifery and medical staff. Appointments had been made that would increase the staffing levels for the service and increase support for staff within the service.
- Staff described their concerns about relocating the Early Pregnancy Assessment Unit (EPAU) within the trust premises. Staff told us they felt that directorate and trust management had not listened to or fully consulted them about these plans.
- There were long term plans in place for a dedicated women's unit within the trust which would include gynaecology and maternity services.

# Services for children and young people

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

The Milton Keynes Hospital paediatric service cares for children up to and including the age of 16. The service includes an inpatient ward with 22 beds, a paediatric assessment unit (PAU), day surgery unit and day unit. There is a level 2 neonatal unit (NNU) where babies who require additional support following birth are cared for. The trust also provides a community paediatric nursing team.

During the inspection, we visited all areas of the paediatric service. We talked to seven families and 22 members of staff, including support workers, nurses, senior managers, senior clinicians and the clinical lead. We observed care and looked at records relating both to patients and the running of the service. Before our inspection, we reviewed performance information from and about the trust.

## Summary of findings

The service had a good culture of incident reporting and learning from incidents. Staff were clear about their responsibilities with regards to safeguarding. We saw safe medicine practices being adhered to and equipment was safety checked.

There was a risk that the shortage of staff could lead to negative outcomes for patients. Staffing levels in the PAU were reviewed in Spring/Summer 2014 and a business case for an additional 8.79 whole time equivalent (wte) nurses was approved. The trust were in the process of recruiting to these additional posts.

We asked the trust to review the way tongue tied babies were being treated in the main outpatient area. Following our inspection the trust carried out an independent review of the clinics and felt assured the service was safe.

Care was provided in accordance with evidence-based national guidelines. Staff followed specific care pathways, and the Paediatric Early Warning Score (PEWS) system was used to identify patients whose condition needed medical intervention.

Ward managers carried out appraisals for nursing staff and identified training and development needs. Issues and concerns were discussed at ward meetings and in handovers.

# Services for children and young people

Multidisciplinary working was embedded within the children's department, with other services in the trust and with external organisations. This ensured that patients received continuity of care.

In general, this service was caring and compassionate. We found that most people felt well-informed and that staff demonstrated a caring attitude.

The children's and young people's services at the hospital was generally responsive to the needs of the people the hospital was caring for. There was good access to the services, which were flexible in meeting the individual needs of patients.

Clear processes were in place for the governance of the service. Regular meetings were held to discuss areas of good practice and identify where improvements were needed. Staff reported good morale, and each member of staff we spoke with had a good understanding of the running of the service and the key risks within it.

## Are services for children and young people safe?

Good

We asked the trust to review the way tongue tied babies were being treated in the main outpatient area. Following our inspection the trust carried out an independent review of the clinics and felt assured the service was safe.

The service had a good culture of incident reporting and learning from incidents. Staff were clear about their responsibilities with regards to safeguarding. We saw safe medicine practices being adhered to and equipment was safety checked.

### Incidents

- Staff described how they would report incidents and were aware of the requirements in the National Patient Safety Agency (NPSA) incident-reporting guidance.
- We saw that root-cause analysis (RCAs) was carried out when serious incidents took place. We reviewed the last three serious incidents and noted that lessons learned were identified and these were shared with staff at management team meetings and in a monthly team newsletter.
- The service reviewed and analysed incidents on a monthly basis. We reviewed the report for September 2014 and noted that themes and trends had been identified. We saw these were discussed at management meetings and actions to drive improvement were identified.
- The service had identified that it reported a high number of medication incidents. We saw action was being taken to address this, with increased auditing by the paediatric pharmacist.

### Cleanliness, infection control and hygiene

- All areas that we visited were clean and well maintained.
- Cleaning checklists were in place and we noted that the play assistant took a lead role in ensuring that toys were cleaned daily.
- Regular hand hygiene audits took place. However, during our observations on the children's ward we noted staff did not routinely wash their hands between seeing patients.
- Personal protective equipment was available for use by staff in clinical areas.

- There was no link nurse or identified lead within the service for infection control. This would be beneficial to ensure that all procedures being worked to are up to date and being adhered to.
- Isolation bays were in place so that should a patient present with an infectious disease they could be separated from other patients to maintain safety.
- Appropriate waste management systems were in place. This included the use of clinical waste bins and sharps disposal boxes.

### Environment and equipment

- Access to areas where children were cared for were secure. Access to the ward and PAU was by entry phone or swipe card.
- All resuscitation equipment which we looked at was checked regularly and stocked appropriately. However, the provider may like to note that advanced paediatric life support (APLS) manuals or algorithms were not available on any of the resuscitation trolleys which we looked at.
- Other equipment such as scales, infusion pumps and suctions had been checked in line with their testing requirements. We noted that labels were in place to confirm the last check date. These were all up to date.
- The environment within the service was well suited for the children being cared for. It was also well maintained. It was colourful and had had lots of paintings and art work (done by children) on display. There were play areas in each area that we visited.

### Medicines

- A copy of the national formulary was accessible in all children and young people's services to support prescribers.
- A dedicated children's pharmacist was in place. We heard that following an increase in medicine-related incidents, this pharmacist had been carrying out a number of audits in order to improve medicines management within the service.
- All medications were stored securely in locked cabinets, and appropriate arrangements were in place for the storage and use of controlled drugs.
- All fridges that stored medicines had their temperatures checked on a daily basis.

### Records

- Records were kept confidential on the wards and stored in secure cabinets.
- Records across children and young people's services were found to be well completed, accurate and legible.

### Consent

- We spoke with staff who confirmed that patients' consent was sought before any procedures or tests were undertaken. Children and parents we spoke with told us that they had been involved in decisions relating to the treatment offered to them.

### Safeguarding

- During our inspection, we observed that staff identified and acted on safeguarding concerns. We spoke to a member of staff involved in escalating the concerns, who described a good process for ensuring that all relevant people within the service were aware of them.
- During our review of records, we noted that a child welfare sheet was completed for all children as part of their admission to the service.
- A lead nurse for safeguarding children was in place. At the time of our inspection, this role was being covered on an interim basis, but plans were in place for it to be filled permanently.
- Staff said that they had received training in safeguarding. Nurses had been trained up to level 3. Records of safeguarding training showed 100% of staff had completed level 1 training. 82% of staff were up to date with level 3 safeguarding training.
- Staff we spoke with were clear that a named safeguarding contact could be contacted if any concerns were identified or raised.
- We spoke with the leads for children's safeguarding within the trust feedback and support was provided to staff involved in making safeguarding referrals.
- A safeguarding committee was in place that looked at issues surrounding safeguarding within the service and the wider health economy. This enabled lessons to be learned so that improvements to the service could be made.

### Mandatory training

- All staff we spoke with reported that they were up to date with their mandatory training.
- At the end of October 2014, 87% of staff had completed mandatory training requirements.
- 92.4% of staff had up to date paediatric intermediate life support training.

# Services for children and young people

### Management of deteriorating patients

- Clear processes were in place to deal with deteriorating patients. Early warning score systems were in place in most of the areas visited. (Early warning scores are generated by combining the scores from a selection of routine observations of patients, for example pulse, respiratory rate and consciousness levels. Where deterioration is seen, the score increases and early interventions can take place to stabilise the child's condition.)
- The Paediatric Early Warning Score (PEWS) was in use on the wards. The neonatal early warning score was in place on the neonatal intensive care unit.
- We observed the handover of a high dependency patient onto the ward. We noted that appropriate monitoring was in place and that all transfer equipment was available. All necessary documentation was in place and we saw effective communication with the patient and between staff.
- We had concerns with regards to the children's outpatient department; two members of staff that we spoke with in this area could not tell us where the nearest resuscitation trolley was or the arrangements in place should a paediatric emergency happen in this area. This area was staffed by a paediatric-trained nurse for only three days a week.
- Our concern about the children's outpatient department was heightened when we became aware that it was carrying out minor ear, nose and throat surgical procedures for children under local anaesthetic. These procedures were being carried out by a maxillofacial surgeon with no paediatric training. Although a nurse with paediatric intermediate life support training was available, we were concerned that staff within the paediatric department were unaware that such services were being carried out. We raised our concerns with the trust at the time of our inspection. They completed an independent review of the service and told us they were assured the service was safe. Staff had full access to life support equipment and staff were tested to ensure they knew how to escalate concerns.
- A paediatric resuscitation team was in place to deal with any emergencies within the service.

### Nursing staffing

- We asked whether an acuity tool was used within the service in order to assess and ensure safe staffing. We were told that although an acuity tool had been trialled, it had not been successful and was currently not in use.
- The children's ward had recently had a staffing review in line with Royal College of Nursing recommendations and an increased establishment had been agreed. At the time of our inspection the ward was staffed during the day by six registered children's nurses and one healthcare assistant, and throughout the night by four registered children's nurses with one healthcare assistant.
- We were concerned about the staffing levels on the PAU . We noted that this service was staffed at all times with two registered children's nurses and one healthcare assistant. Staffing levels in the PAU were reviewed in Spring/Summer 2014 and a business case for 8.79 whole time equivalent (wte) nurses was approved by the management Board in July 2014. The trust was recruiting to the additional posts. in the interim, six beds were not in use on the PAU.
- Nursing staff on the NNU had been reviewed and a level of five registered children's nurses and one healthcare support worker had been determined as a professionally safe staffing level for a full unit. The trust flexed its staffing levels to accommodate the number of babies that were in the unit, risk assessing this several times each day. Staffing levels were in accordance with activity.
- There were 25 vacant nursing posts. Of these, 8.79 wte related to newly established posts that the trust was actively recruiting to. We were told that the service was being flexible in order to maintain staffing levels; for example, the workload was assessed on each unit and if a staffing shortage was identified then staff from other areas would cover shortfalls. Overtime was offered to staff so that vacant shifts could be covered.
- We heard that, on occasion, bank and agency staff had to be used. The use of such staff could be problematic, because not all the staff were paediatric nurses; some were adult nurses. However, we heard that to minimise risk an induction took place and agency staff were supported by experienced team members.
- The manager of the service told us that a programme of staff training was being undertaken to ensure that staff trained in caring for high dependency patients were present at all times within the children's ward.

- Staffing was monitored by the managers and the matron to ensure safe staffing levels were maintained. Staffing was also reviewed at the daily safety huddle with the rest of the hospital.

### Medical staffing

- The service was finding it difficult to recruit middle-grade medical staff. The middle-grade rotas for paediatrics and neonatology were combined and were staffed by a combination of trainees and trust non-training post holders. Although substantive posts were currently unfilled, locums had been used to cover gaps where necessary with a standard operating procedure in place to utilise staff familiar with the hospital and minimise the use of unknown agency locums.
- The service had appointed in August 2014 four new Consultants to be in post by January 2015. It was recognised that this staffing would strengthen and stabilise consultant cover and reduce the need to use locums.
- An on-call system was in place that meant, in an emergency, medical staff could be contacted for advice out of hours.

## Are services for children and young people effective?

Good

Care was provided in accordance with evidence-based national guidelines. Staff followed specific care pathways, and the Paediatric Early Warning Score (PEWS) system was used to identify patients whose condition needed medical intervention.

Ward managers carried out appraisals for nursing staff and identified training and development needs. Issues and concerns were discussed at ward meetings and in handovers.

Multidisciplinary working was embedded within the children's department, with other services in the trust and with external organisations. This ensured that patients received continuity of care.

### Evidence-based care and treatment

- A good process was in place for determining whether updated or new guidelines from the National Institute for Health and Care Excellence (NICE) were applicable to the service.
- We noted that the service promoted a 'policy of the month', which highlighted to staff new or revised guidance that they needed to be aware of. One member of staff we spoke with thought this was an effective way of communicating.
- We reviewed the local audit programme for the service and noted that various audits were being completed, for example in relation to NICE guidance on urinary tract infections in children. Audits and their outcomes were discussed at the service's clinical improvement group.
- The Manchester triage tool was in use. (This tool determines the priority of patients' treatments based on the severity of their condition, and is widely used in the UK.)
- The neonatal unit took into account guidance and advice issued by Bliss, a UK charity working to provide the best possible care and support for babies and their families.
- The neonatal toolkit was in place and being adhered to.
- The trust's hospital protocols were based on relevant guidelines from NICE and the Royal College of Paediatrics and Child Health. Local policies were written in line with these guidelines and had been kept up to date.

### Pain relief

- We observed that a pain assessment tool was in place to identify and manage pain in children. The pain assessment chart was readily available in each patient's clinical records.

### Nutrition and hydration

- The service gave children and young people a choice of meals. They could choose from either the children's menu or the adults' menu.
- We received negative feedback from the parent of one child using this service. They were disappointed with the food for the children: they didn't think there were enough alternatives on the menu, and said that food was often cold and that they had had to buy their own food. The trust employed a catering assistant who would have been able to support this child and provide alternatives; however, the catering assistant relied on the ward staff to alert them.

- We spoke with a parent whose child had been an inpatient for a number of weeks and had "gone off her food". We saw that a referral had been made by the dietician to the catering assistant, who met with the parent and child to explore their food likes and dislikes. The child was offered choices from a finger-food menu. The finger-food menu contained foods that the child found more appealing, such as 'potato smiles', crisps and vegetarian nuggets.
- During our inspection we saw the catering assistant meet the mother of a child to look at how to provide meals to meet the child's needs.
- Paediatric dieticians were involved in developing care plans for children and providing advice and guidance.
- We heard of a number of initiatives that took place to support children and young people with eating, which included introducing small plates and cutlery.
- A snack round had recently been implemented, which gave children access to soft drinks, fruit and cakes between meal times.
- Both the ward and the PAU had facilities for parents to prepare meals and drinks.

### Patient outcomes

- The children's service participated in national audits for which it was eligible. These included audits for paediatric diabetes, paediatric asthma, childhood epilepsy (Epilepsy 12 National Audit) and neonatal intensive and special care (National Neonatal Audit Programme).
- The trust did not meet five out of 10 the national neonatal audit standards during 2012. We found that this has resulted in an action plan being implemented. Significant improvement had been made with eight out of 10 national neonatal audit standards met during 2013 and to do in 2014. The outstanding items relate to data incompleteness.
- We reviewed in detail the recent local audit undertaken in relation to the high dependency unit pathway. However, we noted that the audit had not been appropriately completed, with various gaps in entries. Staff we spoke with were also not aware that an action plan was in place, so we could not be assured that this audit was being used to drive improvement.
- The service had implemented nursing metrics – a score card that contained month by month data on a series of metrics to assess good patient care, for example accurate and evaluated care records and maintaining privacy and dignity. In September we noted that the service was achieving many of the metrics set. Where these metrics fell below 90%, we noted that feedback was provided to staff in order for improvements to be made.
- We were told about plans in place to develop and implement consultant metrics as a tool to improve patient outcomes.

### Competent staff

- All members of staff we spoke with told us they had regular access to supervision and appraisals. The trust's data showed that 87% of staff within the service had received their appraisal for the current year.
- Staff had good access to training and learning to help support them in their roles.
- All staff that worked with children were provided with paediatric intermediate life support training on an annual basis.
- Staff reported that they regularly took part in simulation sessions called 'staying alive'. The sessions were simulations of potential paediatric emergencies and allowed staff to use their skills and learn from any failings.
- All staff received equipment training and this was monitored in a training log kept on the ward.
- Forty-seven members of staff had taken part in distraction techniques training.
- Regular training sessions were held about respiratory conditions, diabetes and oncology, and were available for all staff to attend.

### Multidisciplinary working

- Staff reported that they had seen an improvement in the way they worked together across the service in last two years.
- We were told of the joint working between ward staff and the community teams, where children came to the ward to receive care and treatment.
- Handovers were multidisciplinary to ensure all staff had up-to-date information about the needs of children within the service.
- There was access 24 hours a day, seven days a week, to psychiatric support for children using this service. The child and adolescent mental health team (CAMHS) reported good working relationships with the paediatric team.

# Services for children and young people

- The service had a multidisciplinary approach to audit and governance. Plans were also in place to allocate lead roles in relation to quality and governance for senior clinicians in the service.
- We noted good practice between the paediatric service and the surgical team. A surgical committee had been developed so that staff within the service could discuss issues and work together in order to provide effective care and treatment to children and young people undergoing surgery.
- No clear transfer arrangements were in place between the A&E department and paediatrics.
- Regular handover meetings took place and handover sheets were in place so that up to date information about each patient could be shared.
- We observed the medical handover on the children's ward. We noted that this was thorough and all necessary information was shared to enable on-going consistent care.

## Are services for children and young people caring?

Good

In general, this service was caring and compassionate. We found that most people felt well-informed and that staff demonstrated a caring attitude.

### Compassionate care

- All areas seen maintained people's privacy and dignity. We noted that two side rooms were in place to ensure that children with cancer and their families were comfortable.
- Parents were able to accompany their children to theatres and recovery areas. We noted excellent practice with the introduction of a bleep system. Parents were given a bleep device so that when their child had finished their surgery they could be notified to be with their child during recovery.
- Most parents on the neonatal unit (NNU) reported that staff demonstrated compassion and understanding. One person said, "It [the care] is excellent; all the staff are wonderful." However, we did receive one negative comment, where one parent was too worried to leave their baby, because staff appeared too busy to provide sufficient care.
- The feedback from children on the children's ward was complimentary about the care the children had received from the doctors and nurses. One child commented, "I like the toys and films and how the nurses treats me."

### Patient understanding and involvement

- Parents told us that they had been kept up to date with their children's needs. We were told that, in general, information was forthcoming and parents did not have to keep asking for updates.
- Parents said they felt listened to and that their concerns regarding their children's health had been taken seriously and their anxieties alleviated.

### Emotional support

- While we were on the NNU, we were told about the emotional support available to women and their partners when problems arose during pregnancy or following birth. There was a dedicated bereavement nurse within the unit, and women would be offered the use of a counselling service.
- The trust worked with a local charity to provide bereavement counselling for siblings and families.
- Every year the trust held a "Tree Service," for families whose child had died at the hospital.
- Plans were in place to provide additional psychological support to children with lone term chronic conditions.

## Are services for children and young people responsive?

Good

The children's and young people's services at the hospital was generally responsive to the needs of the people the hospital was caring for. There was good access to the services, which were flexible in meeting the individual needs of patients.

### Service planning and delivery to meet the needs of local people

- The children's department provided a supportive age-appropriate environment offering a range of activities for children and young people.
- There was no separate adolescent unit. However, we saw that areas had been developed in the paediatric assessment unit (PAU) and outpatient departments that were allocated for the use of adolescents.

# Services for children and young people

- A six-bedded bay within the PAU could be used as an escalation area if there were pressures within the service.

### Access and flow

- This trust used various processes for admission onto the ward. Referrals to the PAU could be made by A&E, the community nursing team or GPs.
- Some children and young people had 'red box' status. This meant they could access the service at any time they required without the need for referral.
- The service had a 48-hour open access policy: if, once discharged, a child or young person deteriorated within this timescale they could come straight back to the service without the need for a further referral.
- There were good links with the paediatric community team. We noted that referrals were made and communicated with this team in a timely manner so that consistent and appropriate ongoing care could be maintained.
- There was a flexible service for new patients aged between 16-18 and they could be cared for within adults or children's services dependant on their needs. If children were still under the care of a paediatrician for a complex or chronic illness, where appropriate, they could stay under the care of the paediatrician until they were 18.

### Meeting people's individual needs

- We heard that the service had a good relationship with an external complex needs team. We were told that the complex needs team had a detailed understanding of the children in the local area with complex needs who might need to use the children and young people's services. When an admission to hospital was necessary, a member of this team would accompany the child under their care. We were told that staff at this hospital had been provided with training such as tracheostomy training in order to support the on-going care needs of children staying in this hospital.
- There was good provision of children and adolescent mental health services (CAMHS) for this service. CAMHS was available seven days a week. We spoke with the CAMHS team, who reported that trust staff had a good understanding of the service, and thought they were contacted and consulted appropriately in order to support young people who were suspected of having mental health problems.
- We noted that, in order to support children with cancer, this service shared care with the John Radcliffe Hospital. Staff told us that they had direct access to all the policies and procedures from the John Radcliffe Hospital and accessed these in order to take a consistent approach to a child's or young person's care. We also noted that a paediatric oncology consultant had recently started within this service. Close links were also in place with the local hospice, Keech Hospice Care. Each cancer patient was a 'red box' patient and had access to the ward whenever they required it. Nursing staff had recently started a programme of oncology training to strengthen the support provided within this service.
- During our review of documentation on the PAU we noted that the service held paper copies of advance care plans. We reviewed these and noted that they were all out of date and required review. We brought this to the attention of staff, who took immediate action to ensure that up-to-date plans were in place for those children and families who had made advance decisions.
- Staff reported that there was access to a translation service if required. However, we noted a lack of available information to support people who spoke different languages and who had different cultures.

### Learning from complaints and concerns

- Complaints were handled in line with the trust's complaints policy. However, we noted a lack of information available within the service to inform people how to make a compliant or contact the Patient Advice and Liaison Service.
- Complaints were discussed at the service's clinical improvement and management team meetings. Outcomes and actions were disseminated to staff through formal and informal meetings as well as the monthly newsletter.

### Are services for children and young people well-led?

Good

Clear processes were in place for the governance of the service. Regular meetings were held to discuss areas of

good practice and identify where improvements were needed. Staff reported good morale, and each member of staff we spoke with had a good understating of the running of the service and the key risks within it.

### Vision and strategy for this service

- The team had a draft strategy in place for this service. We spoke with a very committed clinical lead who spoke enthusiastically of plans for the future. Staff we spoke with had great respect for this member of staff and for this person's vision for the future.

### Governance, risk management and quality measurement

- The service held regular governance meetings where good practice was shared and issues relating to the service discussed. Action planning took place so that identified improvements could be made.
- The service's risk register was not up to date; some risks had not been reviewed since April 2014. This meant that we were not assured that the risk management system was being used effectively to manage and monitor risks within the service.
- Regular auditing took place so that the service could measure its quality against patient outcomes.
- We saw that patient feedback was regularly assessed and reviewed. "You said, we did' posters outlining changes to the service were on display within the department.

### Leadership of service

- Every member of staff that we spoke with told us that the leadership team within this trust had made significant improvements over the past two years.
- We were told that children's and younger people's services had become more visible within the trust, and that staff felt listened to. We were told of ideas that had developed within this service and been shared across other parts of the trust as areas of good practice.
- Our discussions with the leadership team demonstrated that the team was passionate and committed to delivering quality and patient-focused care.

### Culture within the service

- Staff we spoke with told us that morale within the service good. Staff felt valued and many reported being thanked and feeling appreciated for the work they carried out.
- Staff were aware of the importance of reporting incidents and understood how this could influence positive service change and improvement.
- Staff told us they thought they would receive feedback and support from their managers and team members where necessary.

### Public and staff engagement

- We saw various initiatives in place to gain feedback from children and their families. One initiative was the 'pants and tops' patient experience project. Children were encouraged to colour in the outline of a pair of pants and comment on what they did not like about the service, and do the same in a top (t-shirt) to communicate what they thought was good about the service. This feedback was displayed throughout the service.
- The service ran a paediatric awards initiative for staff. We heard of members of staff who had been acknowledged and thanked for their work and dedication through this system.
- The service produced and disseminated a monthly newsletter. We noted that key information was shared, such as how the service was performing, key achievements and areas where lessons could be learned. Staff we spoke with confirmed that the newsletter was a useful tool for keeping them engaged and up to date with their service.
- Staff took part in the annual NHS staff survey.

### Innovation, improvement and sustainability

- We noted that in March 2014 the service had developed and implemented high dependency unit trays. These trays were put in place to reduce risk and support staff to provide excellent care and improve outcomes for children. The trays contained standardised equipment and instructions to help during paediatric high dependency situations. Staff we spoke with were proud of this initiative and thought it had improved the way they worked.
- The trust was investing in two state of the art Oncology suites to improve the provision for children with cancer.

# End of life care

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

## Information about the service

Patients with end of life care needs are nursed on general wards throughout Milton Keynes Hospital. They are supported by a consultant-led specialist palliative care team (SPCT). This team provides specialist advice and support, as requested, and coordinated and planned care for patients at the end of their life, on the wards.

The SPCT is available from Monday to Friday, from 8.30am to 4.30pm, excluding bank holidays. Out-of-hours consultant support and advice is provided through a telephone hotline.

We visited a range of wards, including the stroke and cardiology wards and the Macmillan day unit, which provides a day service for haematology and oncology treatments and also a range of clinics during the week.

## Summary of findings

We looked at 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders and found inconsistencies in how these were completed. This finding reflected the trust's own audits. The trust recognised further action was needed to ensure that DNA CPR forms were completed in full and consistently.

The specialist palliative care team (SPCT) comprised four advanced nurse practitioners, one consultant and a part-time associate specialist doctor. The SPCT also had a discharge facilitator, but we noted there was no administrative support for the SPCT.

The SPCT was familiar with the process for reporting incidents, near misses and accidents using the trust's electronic incident reporting system. A small number of incidents had occurred that specifically related to the palliative care service. We saw that these incidents were reviewed and action was taken to try to improve practice and prevent recurrence.

We saw that processes were in place to share information and learn across the organisation. New processes were in place for the SPCT to review all deaths in the hospital at morbidity and mortality review meetings.

Guidance was in place for the effective use of medicines that supported patients at the end of life. This included

# End of life care

pain relief and medicines to control nausea and vomiting. Information on what to prescribe was clear and it considered the implications of giving medicines to patients with impaired renal function.

The service did not have a centralised computerised patient coordination system containing information about the end of life patients in the hospital; there was a plan to develop such a system in the future. The SPCT attended daily safety meetings ('huddles') and discussed patients who were at the end of life.

End of life care was based on national guidance and best practice. The trust had recently issued a new end of life care policy, it had replaced the Liverpool Care Pathway with a plan called the personalised care plan for the dying patient. Not all staff were confident in the use of this new plan, but the SPCT was training ward teams.

Patients' pain was well managed, and appropriate prescribing was in place to manage symptoms such as nausea and vomiting or agitation. The SPCT supported patients to achieve their preferred place of care. A rapid discharge facilitator was part of the SPCT, whose role it was to enable discharges to take place.

The trust was supporting 50 healthcare support workers from a variety of areas across the hospital to undertake training in end of life care with the Open University.

Our observation of practice, review of records and discussions with staff confirmed that effective multidisciplinary team working practices were in place.

We observed throughout our inspection that staff spoke with compassion and respect to the patients they cared for, and treated them with dignity. Staff were welcoming and friendly. We observed positive interactions between staff and patients, and on every ward we inspected we saw that patients were treated with compassion and empathy.

Emotional support was provided both to patients and their relatives.

The SPCT was available from 8.30 to 4.30pm Monday to Friday. Where patients were identified as being in the last eight weeks of their life, the SPCT engaged the support of an end of life care discharge link nurse to facilitate a rapid discharge, where possible, for patients who wanted to be cared for in their own home.

There was a multi-faith prayer room. It was set up for people practising the Muslim faith, in that screens were available to separate males and females.

Mortuary and bereavement staff followed good practice in responding to the needs of parents who had lost children or babies.

The end of life care service had a vision to improve and to develop high-quality end of life care. Milton Keynes Hospital had an end of life care strategy, produced by the Milton Keynes end of life care strategic implementation group. The SPCT at the hospital was represented on the end of life care strategic implementation group.

The hospital's SPCT took part in audits of the quality of care it provided. The SPCT had a work programme with actions it wanted to achieve to improve its service. Progress against this action plan was regularity monitored.

An executive director was the lead for end of life care; the SPCT reported that this was helping it have a stronger voice within the trust. The SPCT was dedicated to and passionate about ensuring that patients at the end of life received the best possible care. It championed this throughout the hospital.

# End of life care

## Are end of life care services safe?

Requires Improvement

We looked at 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders and found inconsistencies in how these were completed. This finding reflected the trust's own audits. The trust recognised further action was needed to ensure that DNA CPR forms were completed in full and consistently.

The SPCT included, four advanced nurse practitioners, a consultant in palliative medicine working 7 sessions a week. and in addition, an associate specialist doctor carried out one session a week at the hospital. This associate specialist doctor worked the remaining sessions at the local hospice, Willen, which is managed by a different provider. The team also had a discharge facilitator, but we noted there was no administrative support for the SPCT.

The SPCT was familiar with the process for reporting incidents, near misses and accidents using the trust's electronic incident reporting system. A small number of incidents had occurred that specifically related to the palliative care service. We saw that these incidents were reviewed and action was taken to try to improve practice and prevent recurrence.

We saw that processes were in place to share information and learn across the organisation. New processes were in place for the SPCT to review all deaths in the hospital at morbidity and mortality review meetings.

Guidance was 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 the implications of giving medicines to patients with impaired renal function.

The service did not have a centralised computerised patient coordination system containing information about the end of life patients in the hospital; there was a plan to develop this in the future. The SPCT attended daily safety meetings ('huddles') and discussed patients who were at the end of life.

### Incidents

- The specialist palliative care team (SPCT) was familiar with the process for reporting incidents, near misses and accidents using the trust's electronic incident reporting system.
- Any incidents were investigated through the use of root cause analysis and, where necessary, further training was arranged.
- Four incidents that related to palliative care had occurred between April 2014 and November 2014. There were no trends in these incidents. We saw that these incidents were reviewed and action was taken to try to improve practice and prevent recurrence.
- We saw that processes were in place to share information and learn across the organisation.
- New processes were in place for the SPCT to review all deaths in the hospital at morbidity and mortality review meetings.

### Cleanliness, infection control and hygiene

- Overall the standards of cleanliness and hygiene were good and staff demonstrated a good knowledge of procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. Whilst visiting the wards, we observed the nurses sanitising their hands before and after patient contact and wearing aprons and gloves when delivering personal care to the patient.
- 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. 'I am Clean' stickers were placed on equipment including toilet seats, the resuscitation trolley and the fire evacuation trolley. This indicated they had been cleaned and were ready to be used. However, not all areas had cleaning schedules in place to evidence regular cleaning had taken place.
- We saw audits were carried out on the wards we visited for hand hygiene which reported compliance at 90% and above

# End of life care

- 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.
- In the mortuary we found that appropriate guidance was followed for maintaining a clean environment and reducing the risk of infection. Staff were aware of how to report incidents and concerns.

### Environment and equipment

- The Macmillan day unit had achieved the Macmillan Environmental Quality Mark in 2010 and had been reaccredited in 2014. The ward provided a comfortable and well equipped environment for patients and their relatives.

### Medicines

- Syringe pumps were available. An effective tracking system was in place for when patients were discharged from the hospital with a syringe pump.
- Guidance was 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 the implications of giving medicines to patients with impaired renal function.
- Two of the specialist palliative care nurses were able to prescribe medicines, and a further nurse was about to undertake this additional training.
- The SPCT had worked with other providers of end of life care within Milton Keynes so there was consistent practice in relation to prescribing medicines at the end of life.
- An easy-to-follow guide had been produced for medical staff based on evidence-based practice.

### Records

- The service did not have a centralised computerised patient coordination system containing information about end of life patients in the hospital. The SPCT told us it had developed cards for end of life patients so that when they were admitted they could show the staff they were receiving end of life care.
- An electronic records system was planned that would link with the system used within primary care.
- We saw evidence that the SPCT was reviewing records of patients who were at the end of life to review how well these had been completed. This enabled the team to identify areas where ward teams needed more training and or support.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that doctors generally completed mental capacity assessments for patients and that the outcomes of the assessments were recorded on the patient's medical notes.
- 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.
- Not all staff were sure who would complete a best interests decision on behalf of those patients who lacked capacity to consent to treatment. Staff could not recall whether this was covered in the trust's mental capacity training.
- Guidance on the mental capacity legislation states that before a mental capacity assessment is undertaken a carer must have "reasonable belief" that the person they care for lacks capacity to make relevant decisions about their care and treatment. We looked at the trust's policy on when to undertake mental capacity assessments, but it did not mention the aspect of reasonable belief
- We looked at 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders and found inconsistencies in how these were completed.
- We saw a DNA CPR form that had been completed for a patient in the medical admission unit. The patient did not have the mental capacity to understand the decision, but we could not find a clear record of the mental capacity assessment to show that the decision not to resuscitate was made in the patient's best interest.
- On Ward 7, we found a DNA CPR form on a patient's file that had been completed in the community in January 2014. The trust's policy was that this should have been reviewed by hospital staff within 24 hours of the patient's admission, yet we found it had taken three days before the DNA PCR order was reviewed.
- On Ward 7, we found a DNA CPR form that had been completed by a registrar and not countersigned by a consultant within 24 hours.

# End of life care

- On Medical Admission Unit 2, we found a DNACPR had been completed whilst the patient was in Accident and Emergency but there was not a clear record of the consultant's capacity assessment in the medical notes.
- Conversely, we saw three DNA CPR forms that had been completed in accordance with the trust's policy. For these patients, there was clear reference to a capacity assessment in the medical notes.

### Safeguarding

- There were effective safeguarding policies and procedures which were understood and implemented by staff. Staff were aware of the trusts' whistleblowing procedures and the action to take. Trust data showed the majority of staff providing end of life care services had received mandatory training in the safeguarding of children and vulnerable adults. Staff we spoke with demonstrated a good understanding of the different types of abuse and how to detect these
- The safeguarding team told us that staff who raise safeguarding concerns were always notified of the outcome and are supported emotionally by the chaplain and the safeguarding team.

### Management of deteriorating patients

- Staff said that generally the SPCT reviewed a patient within 24 hours of referral. Referrals could be made outside normal working hours to the on-call palliative care nurse.
- Staff showed us a REACT form, which is a form that staff can complete when they require a rapid response to the deterioration of an end of life care patient.
- In addition, the hospital had recently started a daily safety 'huddle' meeting. The SPCT attended this from Monday to Friday. Patient who were at the end of their life were discussed and the SPCT would follow these patients up on the wards.

### Nursing staffing

- The specialist palliative care nursing team comprised four advanced nurse practitioners, who worked from Monday to Friday. One of these nurses was on call at the weekends.
- The SPCT also had a discharge facilitator, but we noted there was no administrative support for the team.
- The trust was using a patient acuity tool to link dependency of patients to staffing levels. At the time of our inspection the tool had been in use for six weeks and the results were not yet available.
- All wards had capacity to be flexible with staffing levels if the dependency of patients increased. A clinical assessment process was in place that was led and approved by the matron or, out of hours, by the clinical site team. Patients receiving end of life care were flagged at the daily safety 'huddle'. This meant senior leaders in the trust had oversight of how many patients needed end of life care on each ward.
- A business case had been put forward for additional staff to work within the SPCT. The staff told us this would allow them to be more proactive in responding to patients' needs.

### Medical staffing

- The SPCT included a consultant in palliative medicine working 7 sessions a week. In addition, an associate specialist doctor carried out one session a week at the hospital. This associate specialist doctor worked the remaining sessions at the local hospice, Willen, which is managed by a different provider.

### Major incident awareness and training

- The mortuary technicians told us they had a contingency plan in the event that the mortuary became full.
- Most of the 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.

## Are end of life care services effective?

Good

End of life care was based on national guidance and best practice.

The trust had recently issued a new 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. Not all staff were confident in the use of this new plan, but the specialist palliative care team (SPCT) was training ward teams.

Patients' pain was well managed, and appropriate prescribing was in place to manage symptoms such as

nausea and vomiting or agitation. The SPCT supported patients to achieve their preferred place of care. A rapid discharge facilitator was part of the SPCT, whose role it was to enable discharges to take place.

The trust was supporting 50 healthcare support workers from a variety of areas across the hospital to undertake training in end of life care with the Open University. Our observations of practice, review of records and discussions with staff confirmed that effective multidisciplinary team working practices were in place.

### Evidence-based care and treatment

- The trust had recently issued a new 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.
- Some staff we spoke to had read the new plan; others were not fully aware of it. Information had been cascaded down in staff briefings. Some staff had received training from the SPCT on the new paperwork, and the SPCT had a plan in place to visit all the wards to ensure staff felt confident. Not all staff felt confident in the use of the new plan at the time of our inspection.
- We saw one patient on Ward 22 who the palliative care consultant had assessed as requiring end of life care, but for whom the trust's end of life care plan was not completed until six days after that decision. No nursing care plan was in place for end of life care for the patient during this period, although guidance for staff was given in the medical notes.
- We saw a patient's records that had the new personalised care plan for the dying patient in place. We saw that the plan gave clear guidance for staff to meet this patient's needs in respect of repositioning, food and fluid intake, and pain relief.
- We spoke with the relatives of a patient who was receiving end of life care and had been discharged home. The relatives described the excellent support provided by the lead cancer nurse.
- Two wards had piloted the AMBER care bundle, but a decision had been made to halt its implementation until the new end of life care policy and documentation had been fully implemented throughout the hospital. (The AMBER care bundle is a tool that provides a systematic approach to managing the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months).
- The trust had revised its end of life care policy and re-launched this at the same time as its new care planning documentation. 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).

### Pain relief

- We saw that patient's pain was assessed and appropriate pain relief medicine was prescribed. None of the patients or relatives we spoke with told us they were concerned about pain relief. We did find inconsistencies in the use of pain assessment tools in some cases.
- Controlled drugs were given in a timely way, and staff told us they prioritised this.
- Two of the nurses in the SPCT could prescribe pain relief for patients. A further nurse was about to undertake the required training.
- Generally we found anticipatory medication was prescribed, This is medication that might be needed for patients who are at the end of life. There was no auditing of anticipatory prescribing taking place.

### Nutrition and hydration

- Protected meals times were in place on all wards we visited.
- We observed that all patients had access to drinks that were within their reach.
- We saw that patients were screened using the malnutrition universal screening tool (MUST), and those who were nutritionally at risk were identified accordingly.
- A red-tray system was used to identify patients who required additional support at meal times.
- A specialised kitchen in the catering department catered for patients who were in need of a specific diet such as containing pureed food. All food that is required to be pureed is cooked on site, pureed and then placed into moulds to attempt to replicate its original form. This made it look more appetising for patients.

# End of life care

### Patient outcomes

- The SPCT supported patients to achieve their preferred place of care. A rapid discharge facilitator was part of the SPCT, whose role it was to enable discharges to take place.
- We did not see any patients during our inspection who wanted to be discharged home quickly, but we saw that mechanisms were in place to facilitate this.
- The trust told us it was disappointed with some of the scores in the National Care of the Dying Audit of Hospitals 2012/13. The trust failed to achieve six out of seven organisational key performance indicators (KPIs) and scored below the England average for the clinical KPIs.
- The SPCT had developed actions to address its scores in the National Care of the Dying Audit of Hospitals. Our observations suggested that improvements had been made and the audit results did not reflect the current situation within the hospital.

### Competent staff

- The trust was supporting 50 healthcare support workers from a variety of areas across the hospital to undertake training in end of life care with the Open University. The SPCT was delivering some of this training. The course covered communication, clinical care and dignity after death.
- Training in end of life care was not part of the trust's mandatory training programme.
- Members of the SPCT held relevant qualifications and were competent to provide specialist advice and support.
- Junior doctors received training as part of their education programme.
- Staff received training in the use of syringe driver pumps.

### Multidisciplinary working

- Our observations of practice, review of records and discussions with staff confirmed that effective multidisciplinary team (MDT) working practices were in place.
- Staff told us that communication and collaboration was effective between teams who met regularly to identify patients requiring end of life care.
- The SPCT was closely involved in MDT meetings.
- No electronic palliative care coordination system was in place which would have enhanced the ability for key information relating to patients' wishes and treatment to be shared across services.
- The SPCT had introduced a card system for patients to show on admission to hospital. The card told staff that the patient was known to the SPCT, and asked staff to inform the SPCT of the patient's admission.
- 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.
- The Macmillan day unit liaised closely with a local hospice's bereavement officer to provide effective support in the community for patients and their families.
- The SPCT had won an award for MDT working from the Journal of Palliative Care in 2013.

### Seven-day services

- The SPCT worked from Monday to Friday, from 8am to 4.30pm. An on-call service operated at weekends.
- The trust had recently appointed a palliative care discharge facilitator, who worked from Monday to Friday. This service did not extend to weekends, because the number of weekend discharges was very low.

## Are end of life care services caring?

Good

We judged the end of life care service to be caring.

We observed throughout our inspection that staff spoke to the patients they cared for with compassion and respect, and treated them with dignity. Staff were welcoming and friendly. We observed positive interactions between staff and patients, and on every ward we inspected we saw that patients were treated with empathy.

Emotional support was provided both for patients and their relatives.

### Compassionate care

- We observed throughout our inspection, and in accordance with the Department of Health's national

# End of life care

End of Life Care Strategy (2008), that staff spoke with compassion and respect to the patients they cared for, and treated them with dignity. Staff were welcoming and friendly.

- We observed positive interactions between staff and patients, and on every ward we inspected we saw that patients were treated with compassion and empathy.
- We observed staff speaking with patients and providing care and support in a kind, calm, friendly and easy-going manner.
- One relative we spoke with was very complimentary about the nurses and said, "The staff are brilliant" and "They always keep us informed."
- Another relative told us, "The ward is very good, and they are getting comfortable care;" however, this relative also said, "You feel as though staff can't see the patients as much as they would like."
- The hospital porters told us about the training they had received to ensure they moved deceased patients between the wards and the mortuary in accordance with the trust's policy and procedure. The training also covered how the porters should ensure that they treated the deceased with dignity and respect.

### Patient understanding and involvement

- Generally, relatives said they had been fully involved in end of life care planning for their relatives, but one relative we spoke to had not seen a care plan.
- Most relatives spoke positively about the doctors, although one relative said, "We have seen four or five different doctors and they give conflicting advice."

### Emotional support

- The trust had a multi-faith chapel with separate rooms for male and female Muslims for prayer.
- There was Friday prayer for Muslims as well as Christian services during the week. Communion could be given at the patient's bedside if they were too ill to attend the chapel.
- The chaplaincy service provided an on-call service seven days a week, 24 hours a day, for patients in the hospital as well as their relatives
- The chaplaincy service told us it conducted last rites and blessed the deceased in the mortuary as required.
- The chaplain worked closely with the SPCT and would attend, as necessary, with the SPCT, to see patients when there was a need to break bad news.
- Staff in the mortuary showed us the memory boxes that were given to parents when a child had died.
- 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.
- Facilities were available for the bereaved to wash the deceased.
- The mortuary waiting room was clean, fresh, 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 manager told us that mortuary staff supported relatives. The mortuary staff told people what to expect when they viewed their deceased relative.
- The mortuary manager told us that they accommodated all faiths and worked closely with Muslim undertakers to ensure that deceased patients were cared for in line with their cultural and religious requirements.
- The trust had a bereavement service that provided support for both relatives and staff following the death of a patient.

## Are end of life care services responsive?

Good

The SPCT was committed to ensuring that patients receiving end of life care services had a positive experience.

The SPCT was available from 8.30am to 4.30pm, Monday to Friday. Where patients were identified as being in the last eight weeks of their life, the team engaged the support of an end of life care discharge link nurse to facilitate a rapid discharge, where possible, for patients who wanted to be cared for in their own home.

There was a multi-faith prayer room. It was set up for people practising the Muslim faith, in that screens were available to separate males and females.

Mortuary and bereavement staff followed good practice in responding to the needs of parents who had lost children or babies.

# End of life care

### Service planning and delivery to meet the needs of local people

- One visitor told us how staff had accommodated the cultural and spiritual needs of their relative extremely well and sensitively.
- A range of information leaflets about the hospital's palliative care service were available for patients and their relatives. These were also available in different languages.
- The chaplain told us that every patient received a leaflet called "Your stay in hospital", which explained about the chaplaincy service. Other information leaflets about caring for dying patients were available for patients and relatives or carers.
- The specialist palliative care team (SPCT) was able to meet people's needs in the hospital, but it had completed a business case for additional staff to enable it to be more proactive in responding to patients' needs.
- Patients at the end of life were cared for, where possible, in individual side rooms to give them more privacy.
- No facilities were provided for relatives to stay in relatives' accommodation overnight. Staff were able to provide temporary beds or recliner chairs in patients' side rooms if relatives wanted to stay overnight.
- Many patients who needed end of life care were cared for on Ward 22 because this ward had the most side rooms. There were no facilities on this ward for relatives, and there was no room in which to have a private conversation with staff.
- The trust had developed a communication booklet which was placed at the end of the patient's bed. It allowed relatives and staff to leave messages for one another. This was well received by staff and relatives alike and aimed to improve communication, which was often a theme in complaints.
- The SPCT provided support and advice to patients at the end of life who were in prison.
- Over the previous six months there had been on average 10-15 discharges of patients at the end of life every month. Data suggested 90% patients were able to achieve the preferred place of care during their last days .

### Access and flow

- Bed occupancy rates in the hospital were consistently above the England average: bed occupancy rates were above 95% for 2013, while the England average remained below 90%.

### Meeting people's individual needs

- One visitor told us how Ward 22 had accommodated the cultural and spiritual needs of their relative extremely well and sensitively.

### Learning from complaints and concerns

- Four formal complaints and two informal complaints that involved the end of life care service had been made between January 2014 and November 2014. The complaints were all investigated, with involvement by the palliative care lead and head of service. Discussions with the relevant ward areas had taken place. Although there was not a clear trend to complaints, communication issues were often included.

## Are end of life care services well-led?

Good

The end of life care service had a vision to improve and develop high-quality end of life care. Milton Keynes Hospital had an end of life care strategy produced by the Milton Keynes end of life care strategic implementation group. The specialist palliative care team (SPCT) at the hospital was represented on this group.

The hospital's SPCT took part in audits of the quality of care the hospital provided. The SPCT had a work programme with actions it wanted to achieve to improve its service. Progress against this action plan was regularity monitored.

An executive director was the lead for end of life care. The SPCT reported that this was helping it have a stronger voice within the trust. The SPCT was dedicated to and passionate about ensuring that patients at the end of life received the best possible care. It championed this throughout the hospital.

### Vision and strategy for this service

- The end of life care service had a vision to improve and develop high-quality end of life care, and followed the Department of Health's guidance on the national End of Life Care Strategy (2008) and End of Life Care Strategy: quality markers and measures for end of life care (2009).
- Some ward leaders said they had been consulted about the recent updated end of life care policy.

# End of life care

- Milton Keynes Hospital had an end of life care strategy produced by the Milton Keynes end of life care strategic implementation group. The SPCT at the hospital was represented on this group.
- The strategy had six objectives: promote the use of advance care planning to enable people to state their end of life care wishes and ensure they are adhered to; ensure high quality end of life care; change the perception of "death is failure" to "a good death is a successful care outcome"; develop transparent processes for access to rapid response end of life care all day, every day; ensure health and social care professionals have access to appropriate and high quality training and education; and improve the coordination of end of life care between varied providers.

### Governance, risk management and quality measurement

- The hospital's SPCT took part in audits of the quality of care it provided. We noted that the SPCT did not have any dedicated administrative support, which had an impact on its ability to submit good quality data.
- The hospital's SPCT had a work programme with actions it wanted to achieve to improve its service. Progress against this action plan was regularity monitored.
- The specialist palliative care service was part of the core clinical division. There was a risk register for the division, and processes were in place for escalating risks to the trust board when required. Risks were discussed at monthly governance meetings.
- Governance meetings also discussed complaints, incidents, audits and quality improvement projects, and planned action as required.
- Inpatient deaths were audited and recommendations were made.

### Leadership of service

- An executive director was the lead for end of life care; the SPCT reported that this was helping it have a stronger voice within the trust.
- The SPCT provided advice and support to staff. It would challenge other teams when necessary. We observed that the team worked well together.
- Each ward had a end of life care champion.

### Culture within the service

- Team working on the wards between staff of different disciplines and grades was good.
- The SPCT told us its relationships with the critical care unit were excellent.
- The SPCT was dedicated to and passionate about ensuring that patients at the end of life received the best possible care. It championed this throughout the hospital.
- Team working between the SPCT and the bereavement service was good.

### Public and staff engagement

- The trust used the Friends and Family test, and results of this were displayed for each ward.
- The SPCT collated the feedback IT received from patients; this was generally extremely positive.
- The hospital worked with a cancer patient experience group. Although this group had a wider role than just end of life care, it did provide advice and support to the SPCT on areas that were important for patients.

### Innovation, improvement and sustainability

- The SPCT did not work in isolation but worked as part of a wider network to improve outcomes for people at the end of life, whatever setting they were in.

# Outpatients and diagnostic imaging

| | |
|---|---|
| Safe | Good |
| Effective | Not sufficient evidence to rate |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |
| Overall | Good |

## Information about the service

Most outpatient clinics at Milton Keynes NHS Foundation Trust are co-located in a main outpatient building, although some clinics such as the breast clinic and treatments and chemotherapy are provided in nearby units. All these units are on the hospital campus. Clinics are held from Monday to Friday, with some additional clinics in the evenings and at weekends to reduce waiting lists, for example for urology. Outreach clinics, for example breast screening, are held in the community. The trust estimates that, in an average week, 560 clinics are held for 37 different health conditions. About 294,400 outpatients are seen each year.

We inspected outpatient neurology, rheumatology, urology, orthopaedic, fracture, respiratory, diabetic, ophthalmology, oral and maxillofacial, and breast clinics. We visited the main x-ray department and the x-ray areas in A&E and for the fracture clinic, which were close to the outpatient department. The magnetic resonance imaging (MRI) service was provided by a private contractor based on the hospital site; we visited this provider to discuss the operation of its service provided to outpatients.

In the course of our inspection we spoke with 28 patients and relatives and 30 members of staff including nurses, healthcare assistants, receptionists and managers. We observed interactions between patients and staff, considered the environment and reviewed performance information from and about the hospital.

## Summary of findings

We found that the outpatients department and diagnostic imaging provided good services.

We found that safety in the outpatient department and diagnostic imaging service was good. Incidents were reported and staff knew how to do this and what to report. We saw learning had taken place in response to incidents.

We saw high standards of cleanliness of equipment and in waiting and treatment areas. The physical environment was attractive and well maintained, but there was pressure on space in some areas. Staff had received training in safeguarding and safe practices were in place.

All patients' notes were electronic and easily accessible to the appropriate medical staff. However, staff mentioned that on occasions consultants' scanned notes were not easy to read. We were told that clinic notes were scanned and added to the electronic system within two days.

We had no concerns about the nursing staffing levels across the outpatient service. The trust had some challenges recruiting sufficient medical staff within certain specialists. Staffing issues had recently been eased with the use of bank staff in the main outpatient department and through employing locums, for example in urology and in the oral and maxillofacial clinic.

# Outpatients and diagnostic imaging

Staff told us they worked in line with national guidance. Multidisciplinary working was effective and staff were well trained and supported to provide good care. However, staff members' understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards varied.

Clinics ran from Monday to Friday, with some weekend and evening clinics to reduce waiting lists. The magnetic resonance imaging (MRI) service was available seven days a week.

Outpatient and diagnostic imaging services were delivered by caring and compassionate staff. We saw numerous examples of patients being treated with dignity and respect and given compassionate care. Patients told us that doctors, nurses and other health professionals answered their questions and kept them informed of their care and treatment. We saw that patients were given information about their treatment.

The most current data indicated that 96.2% of patients waiting for outpatient appointments were seen within 18 weeks. This compared with the NHS standard of 95% and was better than the England average.

An independent survey indicated that patients were given little choice regarding their appointment time.

Only about 1% of patients waited six weeks or more for the results of diagnostic tests. This was better than the England average of just over 2%. The number of patients who did not attend their appointments was under 4%, compared with an England average of about 6.8%.

We noted that many clinics ran late but staff did keep them informed and gave them the opportunity to leave and return on another day.

A translation service was available but we did not find information for patients in any other language expect English. Complaints and comments were taken into account, with changes in the service being made in response.

Staff were committed to the trust's objectives and values. Morale was good, and staff felt well informed and supported by their managers and senior hospital management. Performance was monitored and reported and risks were identified and kept under review. Feedback from patients was encouraged and acted on. Efficiency savings were risk-assessed and investments were made to improve patient outcomes.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good

We found that safety in the outpatient department and diagnostic imaging service was good. Incidents were reported and staff knew how to do this and what to report. We saw learning had taken place in response to incidents.

We saw high standards of cleanliness of equipment and in waiting and treatment areas. The physical environment was attractive and well maintained, but there was pressure on space in some areas. Staff had received training in safeguarding and safe practices were in place.

All patients' notes were electronic and easily accessible to the appropriate medical staff. However, staff mentioned that on occasions consultants' scanned notes were not easy to read. We were told that clinic notes were scanned and added to the electronic system within two days.

We had no concerns about the nursing staffing levels across the outpatient service. The trust had some challenges recruiting sufficient medical staff within certain specialists. Staffing issues had recently been eased with the use of bank staff in the main outpatient department and through employing locums, for example in urology and in the oral and maxillofacial clinic.

### Incidents

- Incidents were reported using the trust's electronic reporting system.
- The staff we spoke with told us they knew what types of incident needed to be reported and how these would be recorded.
- Two serious incidents had been reported in the outpatient department.
- Patients had been informed when incidents had occurred. There had been no long-term impact on health outcomes for these patients.
- When incidents occurred, a root cause analysis process was followed, and subsequently changes in practice had been made.
- Staff told us they knew about incidents and we saw examples of learning taking place.

### Cleanliness, infection control and hygiene

- Clinical areas and waiting rooms were visibly clean throughout the outpatient department and in diagnostic areas.
- Hand-cleansing facilities for patients and staff were plentiful. Monthly hand hygiene audits confirmed that hand-cleansing procedures were followed in the outpatient department. The outcomes of these audits were displayed on noticeboards in the patients' waiting area.
- We saw that staff used personal protective equipment such as gloves and aprons when appropriate.
- Staff told us they were required to follow strict hygiene procedures, for example for wiping down all equipment in the clinical area, including chair legs and computers.
- We saw there was planned renewal of items such as curtains, and our checks showed that these schedules were adhered to. We were told that curtains would be immediately replaced if they became soiled.

### Environment and equipment

- Protective screening in the x-ray area was frequently checked; for example, we saw that lead aprons had been checked twice for holes in the previous five months.
- We found that while some equipment such as the digital scanner in the A&E x-ray area was comparatively new, other appliances such as two ultrasound machines were over 10 years old. Senior managers told us that they were aware that equipment was ageing, but that it was well maintained with regular servicing. The trust was considering contracting a management equipment service to replace equipment on an ongoing cycle.
- Senior managers cited space as a challenge for the outpatient department, especially in ophthalmology, where options to increase the waiting area were being discussed with architects. We saw pressure on space in other areas, such as the main x-ray department; there was no recovery area for patients, who had to remain in the intervention suite. Lack of storage had resulted in oxygen cylinders, wheelchairs and a filing cabinet being stored in a corridor. The main x-ray department had been noted as an item on the unit's risk register.
- Non-mandatory training undertaken by staff included equipment competency training.

# Outpatients and diagnostic imaging

### Medicines

- We checked the storage and management of medicines and found effective systems in place. Refrigerator temperatures were monitored.
- Drugs were stored safely, with all medicine cupboards we checked being locked. Keys to the locked medicine cupboard could only be accessed with a code, by trained staff.
- Prescription pads were kept in locked cupboards.

### Records

- All patients' notes were electronic and easily accessible to the appropriate medical staff. However, staff mentioned that on occasions consultants' scanned notes were not easy to read.
- We were told that clinic notes were scanned and added to the electronic system within two days; if a patient required further treatment in less than two days, a tracking mechanism was in place to locate the documents quickly and scan them as a priority.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- When we spoke to staff, we found that understanding about consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) varied.
- Staff in the x-ray department told us they had received no recent training in the MCA/DoLS. A carer or an escort from A&E might assist in explaining the procedure to a patient, but attempts would not be made to cajole a patient or insist that a patient had an x-ray. Staff would not carry out the procedure and would talk to the referrer.
- An incident had been recorded on the hospital's electronic patient safety incident management tool when there had been three attempts to carry out an x-ray on a patient suffering from dementia. The patient's social worker alleged this was in breach of the MCA. The department had not previously obtained any capacity assessments or information about best-interests decisions. The review of this incident resulted in a change in procedure, with notes about whether consent had been obtained or a best-interests decision made.
- In the breast clinic, training on the MCA was provided on a three-yearly basis. A folder held within the clinic contained a summary of MCA requirements.
- Two urology healthcare assistants were attending an Open University course on mental capacity awareness.

### Safeguarding

- Over 90% of the staff in outpatients had completed mandatory refresher training in safeguarding.
- Safeguarding incidents were rare. Our conversations with staff confirmed that they were confident about the steps they should take if they had any concerns.
- Patients with whom we spoke told us they felt safe when attending outpatient appointments.

### Mandatory training

- Senior managers told us that staff have mandatory training and that, at the time of our inspection, we saw the records that stated over 90% of staff across the outpatient department had completed this training.

### Management of deteriorating patients

- The x-ray department had been using its own form to check patients' details before treatment. Senior managers had been attempting to introduce the World Health Organization (WHO) checklist for radiological interventions. At the time of our inspection, the WHO checklist had been recently launched. Staff said they were reluctant to switch to the WHO form because the in-house form captured more comprehensive information.
- Staff told us that they always ensured that another member of staff was available if they had any concerns about the safety of a patient or of staff.
- In the x-ray department, all patients with spinal injuries were escorted by nurses, and children were escorted by a parent/guardian and a nurse.
- We saw a notice in the x-ray department asking women to alert staff if they might be pregnant.
- We noted that operations on babies with tongue-tie were carried out in the oral and maxillofacial clinic without any paediatric involvement. This is further commented on in the section of this report that looks at services for children and young people.
- We saw that when specimens were collected, they were labelled correctly and taken to a designated collection area. All specimens were recorded in a log for tracking purposes; even when specimens were put in a kidney dish, this was labelled to avoid confusion and mismanagement of the specimen.
- Nursing staff in the outpatient department had basic life support training. Emergency 'grab bags' were available.

# Outpatients and diagnostic imaging

### Nursing staffing

- We had no concerns about the nursing staffing levels within the outpatient areas.
- Staff told us that variable workloads could provide a challenge for the breast clinic, but that the clinic was meeting the target of seeing every patient with a potential tumour within two weeks.
- Urology outpatients was well staffed, with no nursing vacancies.

### Medical staffing

- Staff told us that clinics in the oral and maxillofacial unit were under-utilised. A new consultant had recently been appointed, and a consultant who had retired was working as a locum.
- There was a vacancy for a urology consultant, but a locum had been brought in and, according to nurses in the unit, had integrated very well. However, in the same unit the amount of sessions a consultant would spend in clinic had been reduced which had caused a backlog of patients waiting to be seen.
- Staffing issues had recently been eased with the use of bank staff in the main outpatient department and through employing locums, for example in urology and in the oral and maxillofacial clinic.
- Two of the three radiologists in the radiology department were off because of sickness and maternity leave at the time of our inspection. One agency consultant radiologist had been recruited, with other work being carried out by remaining in-house staff, who worked additional hours. Some less complicated cases were being outsourced. However, only one radiologist was carrying out the most complex interventional work; this created vulnerability if the person were to leave or be off sick for an extended time.
- In radiology, reporting capacity and cover featured in the local risk register.

### Major incident awareness and training

- Staff were aware of emergency procedures in the event of a fire or the need for evacuation.
- Backup generators were available if needed in a power cut

## Are outpatient and diagnostic imaging services effective?

Staff told us they worked in line with national guidance. Multidisciplinary working was effective and staff were well trained and supported to provide good care. However, staff members' understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards varied.

Clinics ran from Monday to Friday, with some weekend and evening clinics to reduce waiting lists. The magnetic resonance imaging (MRI) service was available seven days a week.

### Evidence-based care and treatment

- Staff told us they worked in line with the National Institute for Health and Care Excellence (NICE) guidance and that they worked to local policies.
- Best practice guidance was followed, for example when treating fractures.
- Adherence with NICE guidelines was monitored in the relevant directorate clinical governance meetings. Some specialities were working towards meeting best practice guidelines and tariff requirements.

### Pain relief

- Pain was effectively managed. A patient described the understanding and support that had been received, with the use of relaxation techniques to help with pain relief.
- The hospital ensured that consultants' on-call duties did not have an impact on pain clinics.
- Out-of-hours requests for pain relief were covered by anaesthetists.

### Patient outcomes

- Each year in the NHS there are follow up appointments where patients are asked to return to hospital to have their progress checked or to undergo tests or get test results. Whilst some of these appointments are clinically required, a large proportion are unnecessary. Reducing unnecessary follow appointments releases capacity for the treatment of new patient referrals. New to follow-up patient ratios look at the ratio of follow up appoints in relation to first appointments. These are benchmarked nationally The new to follow-up ratios for outpatients at Milton Keynes NHS Foundation Trust were better than the England average.
- The hospital followed NICE guidelines on speed of treatment.

### Competent staff

- Staff told us that good induction training was provided.

# Outpatients and diagnostic imaging

- Staff confirmed that attendance at mandatory training was good and was monitored.
- Staff told us that training on the use of equipment was thorough.
- Expertise was shared, for example through lunchtime teaching sessions and by experts such as a radiologist talking at the multidisciplinary team meeting.
- There was some access to other training, for example a video on dementia awareness had been shown throughout the trust. Some staff said they felt that more training on dementia would be beneficial.
- Staff in the breast clinic told us that they were encouraged to study for National Vocational Qualifications (NVQs) and foundation degrees. Assistants within the department had become competent to carry out mammograms. One nurse told us about being paid to do teacher training and then providing NVQ training within the hospital.
- Staff we spoke with confirmed they received regular appraisals. Managers stated that only a few staff, such as those recently returned from maternity leave, had not received their appraisal interviews.
- Staff meetings, for example weekly meetings in the x-ray department, outpatient nursing, outpatient reception and medical records all have monthly documented meetings which enabled communication and sharing of learning.
- The trust required staff to refresh their basic life support training annually. The training completion rate in the outpatient department was over 90%. Nursing staff who we spoke with stated they had received basic life support training and so would recognise deteriorating patients and secure a prompt response, for example from A&E, which has life support 'grab bags', including one for infants.

### Multidisciplinary working

- We found evidence of multidisciplinary team (MDT) working in the outpatient department, for example the weekly MDT meeting in urology attended by the full range of professionals involved in patients' care, such as nurses, radiologists and consultants. Information from MDT meetings was usually on the hospital's electronic system within two days.
- There were regular joint clinics in operation. For example, a regular joint diabetes and antenatal clinic and a separate joint HIV and antenatal clinic to ensure the best possible outcome for pregnant women and their babies with diabetes or HIV. There were also joint thyroid clinics. Cardiology operated joint outreach clinics which were supported by two other NHS trusts.
- There were MDT and specialist MDT links with the Oxford University Hospitals NHS Trust, for example to discuss specific patients such as those undergoing removal of kidneys in Oxford. This generally worked effectively, although we were told about some lack of clarity regarding contacts, with some queries from Oxford hospitals coming straight through to nurses.
- MRI provision was outsourced. Our conversations with senior managers in diagnostics and with the private providers indicated that this arrangement ran smoothly, for example with images going direct from the scanner to the hospital's electronic system.

### Seven-day services

- The outpatient department clinics ran from Monday to Friday, with morning and afternoon sessions.
- Weekend and evening clinics were held to reduce waiting lists, for example in urology.
- We were told that extra breast clinics were arranged to meet surges in demand.
- The MRI service was available seven days a week from 7am to 90pm and on call throughout the night.
- The main x-ray unit extended its hours until 8pm when the number of ward patients needing same-day imaging increased.

## Are outpatient and diagnostic imaging services caring?

Good

Outpatient and diagnostic imaging services were delivered by caring and compassionate staff. We saw numerous examples of patients being treated with dignity and respect and given compassionate care. Patients told us that doctors, nurses and other health professionals answered their questions and kept them informed of their care and treatment. We saw that patients were given information about their treatment.

### Compassionate care

- Throughout our inspection, we saw patients being treated with dignity and respect.

# Outpatients and diagnostic imaging

- Chaperones were provided where appropriate, for example if a male doctor needed to examine a female patient.
- A family member told us that the support which staff gave their relative helped the patient cope with their worries about a possible malignant tumour.
- All the patients we talked with spoke positively about the care that staff provided. One patient was moving to another county but still wanted to come to this hospital for their treatment because of the quality of patient care. Another patient told us, "The staff are wonderful – so caring and compassionate."

### Patient understanding and involvement

- Patients told us that they were given good explanations about treatment and that staff were always ready to answer any questions. An independent survey indicated that the trust had made significant improvements over the last year in ensuring that patients were aware of what would happen during their appointments. A patient had noted in the main outpatient comments book that staff were, "very kind and thorough and explained everything clearly".
- Nurses told us that they ensured that people fully understood what medication they needed to take, what it was for and any side-effects.

### Emotional support

- We noted that quiet, private rooms with soft furniture were available, for example in the breast clinic, for patients who might receive difficult news.
- Nurses in the urology clinic told us they would sit in with the consultant when people were given bad news and then take them into a private room to enable them to talk it over. They would make sure that patients had telephone numbers they could ring with any concerns.
- Staff told us that they tried to reduce concern by being clear and open with patients, and that they encouraged patients to return with a relative for the results of tests. A patient commented to us that they appreciated "being told straight".
- All staff we spoke with were sensitive to the potential for people to require support while attending the outpatient department; for example, patients they had concerns about MRI scans, they would be shown the scanner and reassured.
- Consultants had received advanced communication training to strengthen their skills in breaking bad news.

## Are outpatient and diagnostic imaging services responsive?

Good

The outpatients and diagnostic imaging services were responsive to the needs of patients.

The most current data indicated that 96.2% of patients waiting for outpatient appointments were seen within 18 weeks. This compared with the NHS standard of 95% and was better than the England average.

An independent survey indicated that patients were given little choice regarding their appointment time.

Only about 1% of patients waited six weeks or more for the results of diagnostic tests. This was better than the England average of just over 2%. The number of patients who did not attend their appointments was under 4%, compared with an England average of about 6.8%.

We noted that many clinics ran late but staff did keep them informed and gave them the opportunity to leave and return on another day.

A translation service was available but we did not find information for patients in any other language expect English. Complaints and comments were taken into account, with changes in the service being made in response.

### Service planning and delivery to meet the needs of local people

- We were given examples of extra clinics being arranged and opening hours extended, such as in ophthalmology, to reduce backlogs.
- Some nurse-led clinics were held in the community, for example to teach self-catheterisation.
- There were a number of nurse led clinic that ran alongside medical colleagues providing care for patients with Inflammatory Bowel Disease, diabetes, cardiology, vascular, breast, pain and colorectal conditions.
- Where biopsies confirmed that tumours were benign, this information was given to patients by telephone rather than requiring them to attend a clinic.

# Outpatients and diagnostic imaging

- The breast clinic took health promotion to 'hard to reach' groups, for example the traveller community.
- Where needed, translators accompanied staff. The policy was to use interpreters rather than rely on family members, for example when women had mammograms.
- We noted separate-sex provision, including space for wheelchair users in the MRI unit.
- We were told that a matron-led initiative had involved a sensory walk-around that identified areas where there were issues for people with impaired hearing or sight. This had resulted in a change of signage within the department to yellow and black. There were hearing loops at all reception desks, training in signing for receptionists, and letters for eye clinic patients were in large print.
- Radiotherapy patients had to go to Oxford John Radcliffe hospital. Many of those needing this treatment were not drivers, so this resulted in a three-hour round journey. New developments were underway to create a cancer centre at Milton Keynes Hospital to provide a service closer to home.
- Car parking was adequate, although some patients were annoyed about the charges.

### Access and flow

- The most current data indicated that 96.2% of patients waiting for outpatient appointments were seen within 18 weeks. This compared with the NHS standard of 95% and was better than the England average.
- An independent survey indicated that compared to 2013, the hospital had changed significantly more appointments to a later date, and patients were given little choice regarding their appointment time.
- Only about 1% of patients waited six weeks or more for the results of diagnostic tests. This was better than the England average of just over 2%.
- The number of patients who did not attend their appointments was under 4%, compared with an England average of about 6.8%.
- We noted that many clinics ran late. Staff told us that some clinics were overbooked, resulting in long delays. However, patients were notified of delays by notices in the waiting areas and by nurses. They were offered the opportunity to re-book if they needed to leave.
- Several patients we talked with commented on waiting times. Some patients informed us that their visits to the eye clinic usually involved more than one treatment and that they had spent a lot of time waiting between treatments. One patient gave the example of having had a brief sight test followed by an hour and half wait for an appointment with a doctor that only lasted five minutes.
- Other patients made positive remarks about the speed with which they were seen. One patient told us that within 10 minutes of returning home from visiting their GP they received a telephone call offering a cancellation slot for the fracture clinic the next day. Another person was pleased to have been referred straight from A&E to the oral and maxillofacial clinic.
- An associate specialist told us that the outpatient department could get overloaded. For example, the associate specialist was scheduled to see 10 patients that day but had seen 13.
- Efficiency was impaired in the main x-ray department because of the delayed return of patients to the wards. These delays were because of movement to and from wards not being permitted during protected meal times or, as we observed during our visit, because of a shortage of space in the ambulatory care unit. We were told that this could result in the x-ray area being unavailable for up to four hours. The outcome was that care had to be provided to patients within the intervention suite, other patients were delayed, and the expensive resource of a trained team was being under-utilised. Records for the last year indicated that unavailability of the x-ray unit amounted to about a day a month.

### Meeting people's individual needs

- Staff told us that translation services were available for people who required them. However, not all clinics offered printed information in different languages.
- Nurses spent extra time explaining diagnoses and treatments to patients who were unable to read.
- Men with breast cancer were usually given appointments at the beginning of a clinic. A separate waiting room could be used by men and other groups such as prison inmates.
- We found that vulnerable patients such as those with disabilities (including learning disabilities) or dementia were treated sensitively and seen as quickly as possible.
- We saw the breast clinic had been designed to create a calm environment with the needs of the patients in mind.

# Outpatients and diagnostic imaging

### Learning from complaints and concerns

- Staff we spoke with were aware of the complaints procedure and were confident in dealing with complaints if they arose.
- We saw that patients were given opportunities to record concerns, suggestions or compliments, for example in books in the main outpatient department and in the breast clinic.
- We noted that changes had been made in response to patient feedback; for example, changes had been made to the ambience of the lighting and provision of reading matter in the breast clinic. When we looked at the comments in the main outpatient book, about 45% of these were complaints, of which about half were about the new computer-based check-in system. The main concern was lack of privacy; this had been addressed with only the last three digits of a patient's telephone number and their postcode being displayed instead of their full contact details.

## Are outpatient and diagnostic imaging services well-led?

Good

Staff were committed to the trust's objectives and values. Morale was good, and staff felt well informed and supported by their managers and senior hospital management. Performance was monitored and reported and risks were identified and kept under review. Feedback from patients was encouraged and acted on. Efficiency savings were risk-assessed and investments were made to improve patient outcomes.

### Vision and strategy for this service

- Staff we spoke with were aware of the trust's vision and demonstrated commitment to its objectives and values.
- Staff were not aware of any specific aims or objectives for the outpatient department.
- Senior managers told us that they ensured that any business cases they wrote met the objectives of the trust.

### Governance, risk management and quality measurement

- There were risk registers for the outpatient department and for diagnostic services. We found these were up to date and mitigations were in place.
- Any patient safety incidents that occurred in the department were were monitored and analysed.
- Outpatients was part of the surgery division, which was managed by a triumvirate comprising of the director, head of nursing and general manager for surgery. The director had regular one-to-one meetings with the head of each clinical unit.
- Divisional meetings were held with all clinical units to review performance and any complaints received. Feedback from the trust's management board was shared at these meetings.
- Management team meetings were held weekly by each clinical unit.
- The division had performance review meetings with the executive team. A different clinical unit head presented a topic of their choice to the executive team at each of these meetings.
- Performance levels for MRI scanning had been agreed with the MRI provider, and were regularly reported on and monitored.
- A range of audits regarding patient outcomes were carried out,. Audits of access to the electronic document management system ensured that access was legitimate and appropriate.
- The trust had decided to provide nurses in the outpatient department with only basic life-support training was based on a risk assessment. The reduced training time freed nurses to carry out their main duties. We saw how this decision had been through a rigorous process of risk assessment.

### Leadership of service

- Staff told us they felt supported by their managers.
- We received several positive comments about the visibility of the chief executive and of board members.

### Culture within the service

- Senior managers told us they felt very proud of what had been achieved, and staff expressed pleasure and pride in their work. They told us that morale was good. One nurse described the culture as, "very good, very open, very transparent".
- A student practitioner told us that they felt welcomed straightaway, and said, "I love it here – I want a job here."
- Our observations confirmed the good working relationships, and there was apparent mutual respect between staff.

# Outpatients and diagnostic imaging

### Public and staff engagement

- Feedback was encouraged through the use of the Friends and Family test. Patients' comments and complaints were reviewed at senior management level and action taken where appropriate.
- Non-executive directors kept in touch with the service and patients' experiences by doing walkabouts before board meetings.
- Communication was generally effective, for example with minutes of meetings being emailed around within two or three days. A part-time member of staff commented that this helped them feel well informed. However, the reasons for some decisions, such as the change to only providing basic life-support training to nurses, were not always effectively communicated.
- Senior managers' photographs were included in emails and newsletters. The senior managers told us they tried to be visible and approachable.
- Staff nominated for performance awards were invited to divisional meetings to give them insight into management processes.

### Innovation, improvement and sustainability

- Efficiency savings had been risk-assessed by the director of nursing and medical director and were achieved without affecting the service to patients.
- Staff reported that work with neighbouring hospitals was effective and increased resilience when there was pressure on resources.
- A new digital mammogram machine enabled faster patient throughput. It had also meant the trust could screen women from the age of 47-73 instead of age 50-65. At least 20 extra cancers had been identified as a result.
- Business cases were required to support requests for investment, for example to provide a recovery area in the main x-ray unit.
- An external expert had been invited to review the urology service. As a result the trust had invested in two additional consultant urology posts to be shared with another NHS trust. , Tactical planning was being used to review patient pathways and identify more efficient ways of working.

# Outstanding practice and areas for improvement

## Outstanding practice

- Sensory walk rounds had taken place in the wards and departments and had led to improvements for people who had visual impairments.
- The Cancer Patient Partnership group was providing the trust with an outstanding way of engaging with patients and the public. There was good engagement between staff and the member of this group which had led to improvements in patient care.
- The care delivered by staff working in bereavement teams was good, this included the care provided to women and their partners after a bereavement of a baby. The bereavement specialist midwife had recently won a national award for her work in the trust's maternity service.
- Leadership within surgery was "outstanding." There was a shared purpose, excellent relationships were in place and there were high levels of staff satisfaction. Staff were very committed to working together in order to improve quality for patients.
- Consultant medical staff were extremely engaged with the leaders in the trust and were very positive about the future for Milton Keynes Hospital.

## Areas for improvement

### Action the hospital SHOULD take to improve

- The trust should ensure that patients in the waiting area in the medical assessment unit (Ward 1) have a means of calling for urgent help if required.
- The trust should ensure that cytotoxic waste is always stored securely.
- The trust should ensure that full and accurate records are maintained in relation to the care and treatment provided to each patient. This should include accurate recording of venous thromboembolism risk assessments for all patients, dementia risk assessments for patients aged 75 years or over, and records of food and fluids for patients assessed at risk of inadequate nutrition and dehydration.
- The trust should ensure that there are suitable arrangements in place for all staff to receive appropriate training and appraisal.
- The trust should ensure that patients who need inpatient care and treatment are transferred from the medical assessment unit to an appropriate ward within 72 hours.
- The trust should ensure pre-operative safety checks are carried out in accordance with WHO for all types of surgery, including dental extractions.
- The trust should ensure there are cleaning schedules that include equipment such as shower chairs and stools.
- The trust should ensure patients privacy and dignity is maintained with the A&E department.
- The trust should ensure the completion of DNACPR documentation is consistent across the hospital.
- The maternity and gynaecology governance team should ensure appropriate and timely monitoring, updating and checking for the completion of action plans that had resulted from serious incident investigations or root cause analysis to ensure lessons were learnt.
- The trust should consult with the trust's health and safety and fire teams to establish operational protocols for partners who remain on Ward 9 overnight.