healthwatch
Milton Keynes

Enter and View

Milton Keynes University Hospital

27 November 2025

1 Contents

2 Introduction

2.1 Details of visit

Name of home	Milton Keynes University Hospital (MKUH) Wards 2a, 2b, 5, 3, 17, 19, 20,21a & Hospital Restaurant
Service provider	Milton Keynes Hospital NHS Foundation Trust
Date and time	27 November 2025 between 10am and 5pm
Authorised representative (s)	Tracy Keech, Helen Browse, Colin Weaving, Diane Barnes, Gill Needham.

2.2 Acknowledgements

Healthwatch Milton Keynes would like to thank the service provider, staff, service users and their families for contributing to this Enter and View visit, notably for their helpfulness, hospitality, and courtesy.

2.3 How we gathered the data

This report is based on our observations and the experiences of the patients, relatives and staff we spoke to on the day of the visit.

Disclaimer

Please note that this report relates to findings observed on the specific date set out above.

3 What is Enter and View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families, and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists, and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service, but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first-hand.

Healthwatch Enter and Views are not intended to identify safeguarding issues specifically. However, if safeguarding concerns arise during a visit, they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about, they need to inform their lead, who will inform the service manager, ending the visit.

In addition, if any staff member wishes to raise a safeguarding issue about their employer, they will be directed to the Care Quality Commission, where they are protected by legislation if they raise a concern.

3.1 Purpose of visit

The purpose of this visit is to understand how well the hospital takes account of patients' pre-existing health conditions and additional needs during their stay, and how this affects their overall care experience.

3.2 Strategic drivers

Healthwatch Milton Keynes gathers ongoing feedback from local people about their experiences of care at Milton Keynes University Hospital (MKUH). This feedback has consistently highlighted positive experiences of treatment for the condition for which patients were admitted. However, insights from individual patients and patient groups, including Parkinson's disease support groups and people with physical disabilities, indicated that patients' pre-existing health conditions and additional needs may not always be fully reflected in their day-to-day care during a hospital stay.

Healthwatch recognises the operational pressures under which acute hospitals operate, including high demand and workforce challenges. However, understanding and responding to patients' pre-existing conditions and additional needs remains a fundamental part of delivering safe, dignified, and person-centred care, particularly for people with long-term conditions or disabilities.

This Enter and View visit was therefore strategically undertaken to explore how MKUH identifies, records, and responds to patients' pre-existing health conditions and additional needs during their stay, and how this information is shared and used by staff to support holistic care. The visit aimed to gain a clearer understanding of current practice, recognise areas of effective practice, and identify any opportunities to further enhance patients' overall care experience.

4 Overall summary

We visited eight wards in total, speaking with patients and their family members where appropriate. In addition, we spent time in the hospital restaurant talking with family members, visitors and staff about their experiences on the wards.

In total, we spoke to **54** patients and their family and friends. Overall, **68%** (37) had pre-existing health conditions that were not necessarily the reason for this admission.

Over half (31) of these patients had come into hospital with their own medications. **57%** of these patients told us their medication was being administered by hospital staff.

As patient feedback was gathered on the wards during the day, common themes began to emerge:

- All wards were welcoming and were aware of our visit; staff were helpful in all instances.
- Patients and family members were often confused over discharge plans, and felt these needed to be made clearer.
- Patients said that staff are very busy, leaving little time to converse with patients at any time during the day, evening, or night.
- We recorded inconsistencies between wards in the way names, medications, dietary instructions etc were recorded above beds. These ranged between emojis, pictures, and written notes, to nothing at all on some wards. This could lead to confusion, particularly for bank staff. Best practice would be a consistent approach throughout the hospital.
- Hard of hearing patients do not fare well with little signage to aid them, and staff not taking the time to stop and look at them while speaking.
- Dementia patients in beds on general wards tended to cause distress for other patients.
- Food was felt to be good by most patients however, people with special dietary requirements did not agree.
- Nursing staff were felt to be far too busy. They were seen as kind and caring but patients felt that too much was asked of them.

5 Methodology

This was an announced visit. We liaised directly with the Milton Keynes University Hospital Foundation Trust (MKUH) Head of Patient & Family Experience to agree the date, timing and objectives of the visit. Posters were provided to MKUH in advance with a request that these be displayed in all areas that would be visited with an overview explanation of the purpose of the visit also provided. We used the hospital website in advance to look at locations for each of the wards, whilst in the hospital using signage to find our chosen locations.

The Authorised Representatives (ARs) arrived at 9.30 AM and actively engaged with patients between 10:30AM and 5:00 PM.

On arrival, the ARs introduced themselves to the Patient Experience Lead, and the visit details were discussed and agreed. The ARs were subsequently afforded access to all public parts of the Hospital necessary for the duration of the visit.

Healthwatch Authorised Representatives made themselves known to the most senior staff member on duty in each ward visited and provided them with a letter confirming the purpose of the visit. At this time, the ARs talked to the senior staff member about the patients on their ward. This meant that we were fully briefed on which patients it would be inappropriate to disturb because of the nature of their condition, or those who were unable to give informed consent.

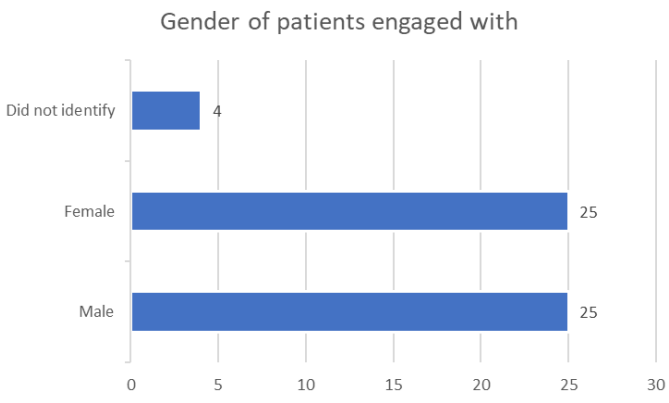
The ARs used a semi-structured conversation approach in meeting patients on a one-to-one basis. Additionally, the ARs spent time observing routine activity and the provision of lunch. The ARs recorded the conversations and observations via hand-written notes.

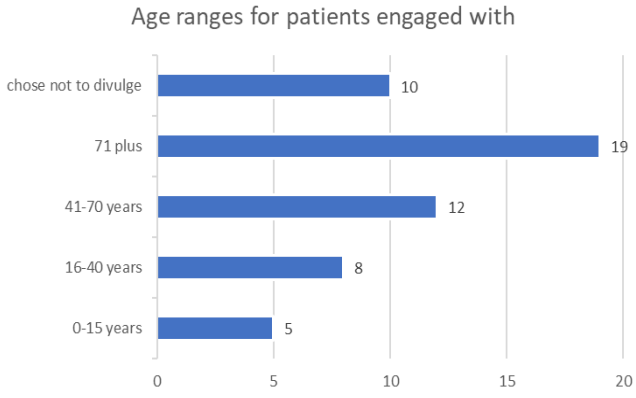
Patients were approached and asked if they would be willing to discuss their experiences. It was made clear to patients that they could withdraw from the conversation at any time.

A total of 54 patients and or family members took part in these conversations.

The length of stay for the patients we engaged with varied from two days to six weeks in duration and some patients had been in one or more wards in the hospital during their stay.

In respect of demographics:





6 Summary of findings

6.1 Overview

The visit took place on a Thursday. As expected for winter, the hospital was busy, but not out of the ordinary. Staff were welcoming and helpful throughout the visit, and any areas for improvement noted were practical or environmental rather than related to the quality of care. A doctor's strike the previous week did not affect the visit, and there were no staffing issues on the day. A flu outbreak on one ward was managed effectively by staff.

Patients generally welcomed being approached and appreciated the company, as there is limited social interaction or entertainment available on the wards. Many noted that staff are extremely busy, leaving little time for conversation during the day, and some patients have few visitors, partly due to limited public transport options. Despite these pressures, most patients described staff as kind, caring, and committed.

Some practical challenges were observed when navigating the Hospital. The hospital's website can be difficult to use, with ward names sometimes differing from signage within the hospital. This can make finding the correct ward challenging, particularly for people with mobility issues or those relying on public transport.

Of the 54 patients we spoke with, 68% (37) had pre-existing health conditions that were not necessarily the reason for their hospital admission. Many of these patients (31) brought their own medications with them, and in just over half of these cases (57%), hospital staff administered the medications. A few patients self-managed certain treatments, such as inhalers or blood pressure tablets. Two patients were having their medications reviewed, and one had a change made to their medication during their stay. Several patients commented that communication about changes to their medication could be clearer.

When asked if pre-existing conditions were being managed well in hospital, only 46% of patients responded (25).

Of the 25 people who chose to answer the question about how well their pre-existing condition was managed during their hospital stay: 14 said they felt it had been well managed, five reported a poor experience, and six described a mix of good and less positive experiences.

6.2 Premises

Some areas of the hospital are newer than others and patients were really impressed with their surroundings in the New Maple Unit. However, those in the older parts of the hospital were not so complimentary. They were quick to point out ceilings, walls, doors that required maintenance, excessive lighting late into the night and call bells that were out of reach.

- Maple Unit is well appointed, spacious and well-lit. Patients appreciated the newness of the surroundings but when transferred to other wards for longer term stays, they felt the difference in their surrounds more keenly.
- General maintenance on some wards is poor. Paintwork and woodwork is in need of repair, ceiling tiles stained and poorly fitted.
- Patients' bedside storage and trays were not consistent throughout the hospital. Overbed tables/lockboxes beside beds were missing or in poor condition.
- Patients' who require assistance to mobilise have little opportunity to get out of bed due to staff availability.
- At mealtimes there is little space in the main restaurant for visitors as it is so well used by staff. This is a positive but also makes it difficult for visitors, especially when they have loved ones in wards with protected mealtimes.
- Temperature is difficult to agree on across any building, but Ward 5 seemed to be the only ward where we heard it was too warm. Parents agreed that small children needed to be kept warm, but all felt it was overly warm and stifling.
- Overall impression of cleanliness and maintenance was that the wards needed some TLC, but the cleaners were working hard to keep the wards clean.
- There were 'Out of Order' signs on toilets on some wards. The toilet and bathroom facilities were below the standard that was expected. The facilities in public areas required attention.
- Flooring on some of the main corridors in need of repair/replacement, with lifting and tears which could be trip hazards as well as potentially not meeting infection control standards.
- There is little or no dementia signage in the hospital. It might be practical to label all bathrooms and taps as a starting point.
- Elderly patients have few visitors as partners find it difficult to visit. We were told that buses do not drop off at convenient stops anymore.

6.3 Staff interaction and quality of care

Staff interaction and quality of care on all wards we visited had common themes:

It was clear from the responses given by patients and family members that staff were well liked. However, it was also clear that patients felt there were insufficient staff, and that staff were all very busy and expected to do too much.

There was concern that, when the staffing was so lean across the wards, if one patient needed the attention of more than one staff member, it left every other patient on the ward with no one looking after them.

Nurses don't have the time to spend with patients that either they or the patients would like.

Patients told us they were washed but not always offered a shower or encouraged to get dressed. Sometimes just the essentials were offered as multiple staff are required to help some patients more fully, and this is not always convenient or possible due to the numbers of staff on shift. Bedbound patients said they felt their personal care was inadequate at times due to the shortage of staff.

Patients and relatives were, overall, confused about discharge processes. A few relatives told us they did have a clear understanding and knew that checks had been made to ensure a safe transition to home would happen even if the timing was not made clear.

Boredom was a concern as there are no TV's available on most wards unless patients are able to get out of bed and visit the day room. Most of the patients we spoke to said this was not possible without assistance, and the lean staffing model meant that assistance was not always available.

General observations

Whiteboards and signage behind beds: Lack of consistency through the wards - some use emojis some written words, some have nothing at bedside.

Hard of Hearing emoji/ Interpreter required: This was not seen anywhere in the wards we visited.

Discharge process: Patients found this challenging - as did relatives. Lack of wheelchairs. Poor communication from nurses, little guidance to relatives on release times if any.

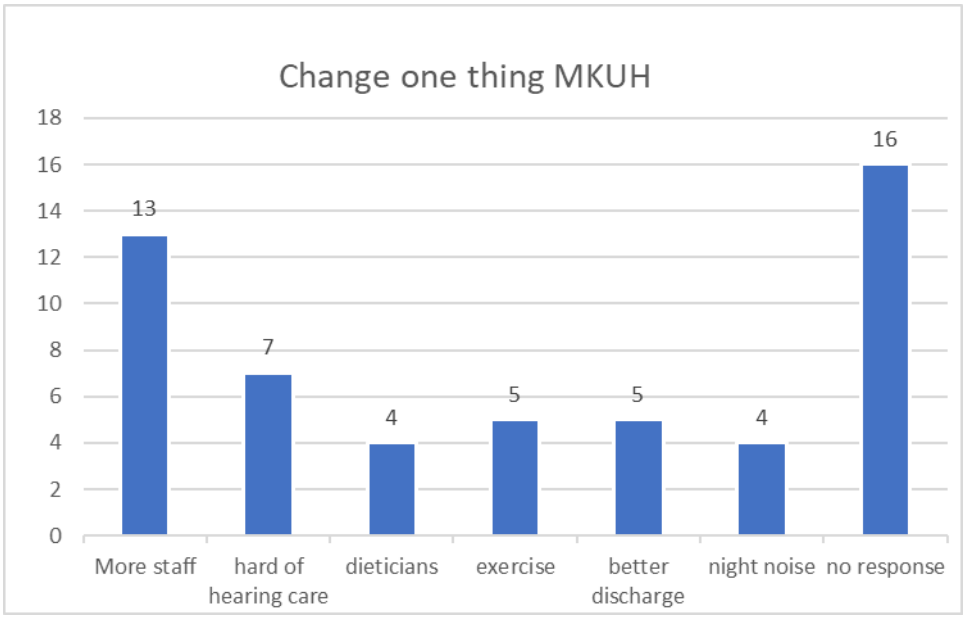
Ward mix - dementia patients wards: This causes issues for patients with and without dementia.

Boredom on wards: No TV's at bedside, few visitors (particularly elderly) as access is difficult due to transport issues. This can impede recovery.

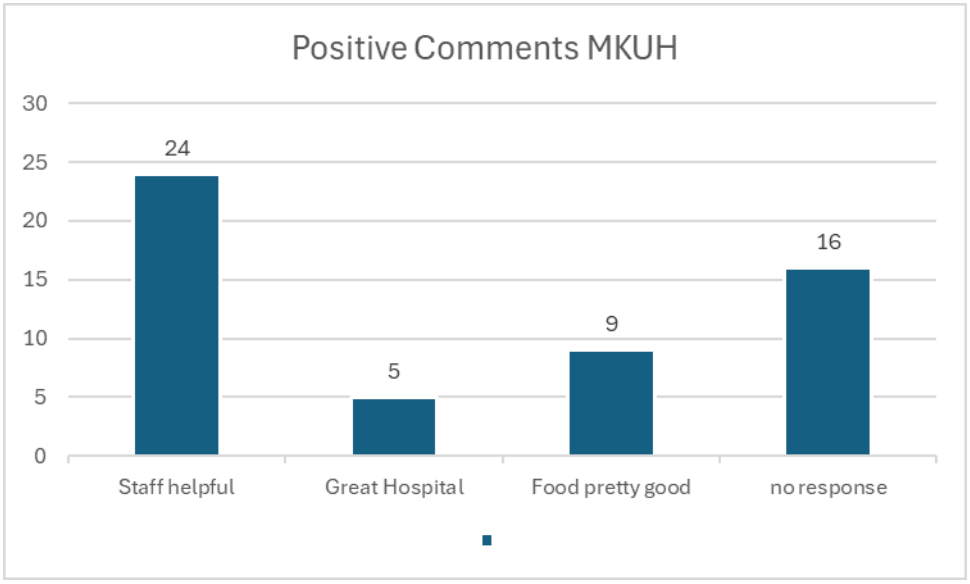
General cleanliness: Overall, wards appeared messy, unkempt and in need of a thorough clean.

As always, we finished our conversations by asking two questions: If you could change one thing, what would it be? And: What is one positive about your admission? We were not surprised to see that helpful or caring staff was the most positive part of people's hospital stay.

If you could change one thing about your stay at MKUH, what would it be?



What is one positive about your stay?



7 Voices from the Wards

We took a hospital-wide view when selecting wards to visit, with the aim of reflecting a broad range of services. Wards were chosen where visits could be carried out under normal conditions, without the need for special measures or disruption to routine ward activities.

We visited eight wards plus the main restaurant on an average winter Thursday. We spent between 10.30am and 5pm speaking to patients, relatives, visitors, and staff.

Maple unit Ward 2a – short stay

Patient profiles: Five patients aged 24–82; mostly White British males; conditions include neurodiversity, falls, and complex chronic conditions. Patients had been on the ward for 2 -6 days.

- Handwritten notes above most beds, no symbol system in use.
- Visitor toilet/day room out of order.
- Mostly positive staff interactions.
- Most patients felt their pre-existing conditions were understood, and medication was managed by staff (including timed medications).
- Several patients described boredom, because there was no access to TV, and no time for conversation because staff were visibly stretched.
- One serious safeguarding concern was raised about night staff requesting to see a patient's bank card; this was escalated to MKUH management at the time.

"Would like more opportunity to get out of bed but need assistance."

"Staff, all types, are so busy — they have so much to do."

"Bored, no TV… nurses have no time to chat."

A parent praised extraordinary staff compassion:

"I couldn't speak highly enough about their treatment of him."

Ward 2b – Acute medical short stay

Patient profiles: Seven patients aged 70–90, with frailty, hearing impairment, falls risk, and chronic conditions.

- Minimal bedside information: where present, it was handwritten, often only ‘fluids’ or ‘red tray’.
- Most patients did not realise their yellow wristband indicated a falls risk, though all knew they needed mobility support
- Noisy at night, particularly from staff interactions.
- Personal items not in bedside cupboards but on display, causing distress as wallets are on show but patients feel they can’t protect them.
- Medication understanding was poor across the ward; patients who had brought their medications in did not know where it was stored or whether changes had been made.
- A patient needing support with washing felt staff were embarrassed or hesitant when showering them. This made the patient feel uncomfortable with their help.
- Hard-of-hearing patients struggled greatly due to no signage to alert staff, staff speaking while looking away, and high ambient noise. A hard-of-hearing patient noted: ***“If they could ALL look at me… I lip-read.”***
- Patients would all like to have a little exercise during the day, but staff are too busy for this to happen

“Staff get top marks — very good.”

“It’s very noisy at night when staff get together.”

“Feels like staff are run ragged.”

“I’m very comfortable and staff are friendly and nice.”

We learned that one patient was a veteran, they were unaware that the Hospital had an armed forces team who could have visited.

Most patients were waiting for information on when they might be discharged. Family felt that this could be communicated better.

Patients who had moved from other areas of the hospital commented on the poor state of the building compared to ‘the New bit’.

Ward 3 - Female complex & dementia

Patient profiles: Eight patients aged 54–91; significant dementia, mobility issues, diabetes, visual impairment, palliative care. Length of stay ranged from 2 days - 6 weeks.

- Excellent use of emoji symbols above most beds: dementia, diet, eating assistance, and risks well-marked.
- Patients noted as falls risk told us their walking aids were stored away from their beds.
- Allergies and assistance needs were clearly documented.
- Mix of dementia and non-dementia patients caused distress at times.
- Limited entertainment — no TVs, except for one patient with 1:1 support watching music videos.
- Pre-existing conditions widely present and well-documented.
- Medications kept in lock boxes and administered by staff; only one patient had an ongoing medication-related concern which the Hospital was already aware of and were dealing with.
- Patients report the ward temperature is “up and down”.
- Patients consistently praised staff compassion and attentiveness.

“Staff are great.”

“Love it here — staff are great and so is the food.”

“Care plan in place but waiting for Occupational Health.”

“Night staff could make more effort to read patient notes so we don’t have to fill them in on our needs.”

Ward 5 – Paediatric age 0-15yrs

Patient profiles: Five patients/ parents aged **3 months–13 years**; complex needs, allergies, epilepsy, respiratory illness. **3 of 5** had pre-existing conditions and previous admissions. Length of stay ranged between **3 days to 2 weeks**

People we spoke to who had been on both ward 4 and ward 5 told us that the communication was better on ward 5 but that it still required improvement.

- Staff training on equipment was questioned, particularly in relation to feeding machines, as not all 1:1 nurses were able to tell if equipment was functioning correctly or able to reset it when issues arose.
- Some children need to be moved/turned regularly, and this did not always happen as frequently as parents would like. Parents who could not stay all day and night because of family commitments had concerns.
- Difficulties with menu for food intolerances for babies and children. Parents said there was little or no dairy-free option on the menu for babies/toddlers, and that dieticians do not visit the ward.
- The ward was felt to be far too hot, and the lighting was too harsh. Parents understood the need for a warm environment but felt that it was too hot and that the lights were not dimmed enough to allow good sleep.
- Older patients found being so close to the babies could be distressing when the babies were crying.
- Complaints that the ward phone is often not answered, so if parents are not able to be on the ward they cannot get updates on their children.
- The biggest request was for better communication on the ward from staff to parents/guardians.
- Older children want to be included in conversations about their health and would like staff to talk to them, not just their parents/ guardians.
- Overall, the nursing staff were well liked.

"Most people don't talk to me, they talk to my Mum or Dad, it would be nice if they talked to me more."

"Staff on 5 are fantastic."

"It's far too hot on the ward."

"Less lighting at night."

Ward 17 - Cardiology

Patient profiles: Seven patients aged **55–85**; chronic cardiac conditions, Down Syndrome with dementia, recurrent admissions. Length of stay ranged between **5 days - 6 weeks**

- No patient information was displayed on bed boards; names and care details were not visible.
- Three patients had pre-existing conditions and told us these were being managed well by staff.
- One patient had brought their own medications from home, which were stored in a lock box. A medication review had been requested by staff prior to discharge as there is a difference of opinion between patient and staff on the volume of medication that should be taken. At the time of our visit, staff were dispensing medication.
- For all patients spoken to, medications (including patients' own) were administered by staff.
- Staff were consistently described very positively by patients, despite being visibly busy and under pressure.
- Food quality was reported as good but the menu became monotonous for the longer stay patients.
- Not all beds had over-bed tables
- People told us the toilets were not clean.

The ward environment was observed to be run down and in need of refurbishment. Walls, flooring, and lighting, contributing to a ward environment our ARs described as "quite depressing."

Staff had very limited time to spend with patients. In fact, this ward appeared to be the most short-staffed that we visited. Despite this, staff were providing high-quality care, and this was noted by everyone on the ward.

"Great treatment, staff absolutely Brilliant."

"Great treatment on this ward."

"Looked after very well by staff and communication is good."

Ward 19 – Acute general

Patient profiles: Three patients aged 70s–80s; dementia, post-surgical complications, infection recovery. Two patients had been in Hospital less than a week, and one patient only said, "too long!".

- No patient information was displayed on bed boards; names and care details were not visible.
- All patients reported having pre-existing conditions, and their medications were administered by hospital staff.
- Patients had very different and sometimes complex needs. One person described a difficult journey through the hospital, arriving in A&E at 4pm, having no meds or fluids until being moved to Ward One at 8am, and then transferred again to Ward 19 at 10pm.
- Communication was the only concern raised. Patients said staff were good and treatment was positive, though people living with dementia would benefit from closer observation and clearer communication.
- One bay was closed due to a flu outbreak, meaning no visitors to that bay and restricted staff movement. Patients and staff were required to remain within designated areas for safety.
- Visitor access remained highly restricted due to the flu outbreak, while discharge processes continued for patients in other bays. The management of this outbreak was generally thought to be well done.

"Doctors' bedside manner is good but the consultants not so good - communication needs improving."

"Staff to be more observant about needs [of people with dementia who may not verbalise or use the call bell]."

Ward 20 – Colorectal surgery

Patient profiles: Seven patients, 2 men and 3 women, aged 30–70+; emergency surgery, bile duct issues, pancreatitis. Length of stay ranges from 1 – 7 days.

- Some beds have handwritten notes.
- LFD noted on some whiteboards. HWMK assume, after researching, this means Low Fibre Diet. Because of the inconsistent use of whiteboard notations, we wondered whether the catering team are aware of this when bringing meals and snacks.
- Most patients reported that medications were administered by staff; some patients had brought their own medications from home.
- One patient reported significant and ongoing concerns regarding medication management, including missed or delayed doses (thyroid medication, asthma inhaler, pain relief), confusion around self-medication, and delays in prescription updates following pharmacist review.
- Another patient who brought their own medications reported being satisfied with staff administering them and preferred this approach to avoid taking multiple medicines.
- One patient reported repeated delays in receiving pain relief, particularly overnight, and described feeling distressed by staff responses to pain requests.
- Staff were frequently described as very busy but hardworking, with several patients praising the quality of care and professionalism.
- Positive feedback included comments that staff "do a really good job," and that the hospital was "great," with good food and care.
- Communication around discharge was inconsistent, with at least one patient reporting no discussion following surgery.
- Overall, patient experience on the ward was mixed. It ranged from very positive feedback to one account describing significant distress and loss of trust in care, particularly relating to medication safety and pain management.
- Despite concerns raised, individual nurses and healthcare assistants were acknowledged as kind and supportive by multiple patients.

"Care is good here - they do a good job."

"They do a really good job here, great hospital."

"Staff have been great, really understanding."

Ward 21a – Elective hips & knees

Patient profiles: Five patients aged 40–70; elective orthopaedic procedures with controlled chronic conditions. Length of stay ranged from 2 - 5 days

- Four out of five patients had pre-existing conditions and had brought their own medications to hospital.
- Three patients reported self-administering their routine blood pressure medication, and said staff had not asked for their medicines on admission.
- In one case, a patient's medications were placed in a lock box, and staff had requested a medication review prior to discharge due to differing views on dosage.
- Patients consistently described care as good, with staff taking "very good care" of them or their relatives.
- Staff had discussed discharge arrangements with families, although in one case a patient's family had organised the loan of equipment for the home through Red Cross.
- Discharge planning was generally underway and understood, though some patients felt staff relied on families to make their own arrangements.
- Patients did not express significant concerns about how their pre-existing conditions were managed, suggesting that these were not seen as problematic in the context of their elective admission.
- One 70 yr old patient told us their 07:15 surgery time had been moved to the afternoon, and they were not able to eat or drink until then.

"Care has been good."

"Staff take very good care of Mum."

"Staff have discussed discharge arrangements with the family, but my daughter has made all the arrangements for home help and aids herself."

Staff are generally described as caring, but there is uncertainty about:

- Whether staff routinely check brought-in medications.
- When self-medicating is permitted and when it is not.

Restaurant – main hospital - Blue Zone

We engaged with four service users/visitors and spent a large part of the day observing, meeting with the team and hospital staff for updates throughout the day. This provided useful insight into how the space supports patients, families, and staff throughout the day. Here is an outline summary of these conversations:

Wife of a patient undergoing outpatient diagnostics

We spoke briefly with the wife of a patient who was undergoing an outpatient diagnostic procedure. She was waiting alone in the hospital restaurant while her husband was being tested and described feeling extremely anxious about what the results might show. Although she was initially willing to talk with us, she became visibly upset and said she was too emotional to continue the conversation.

Patient attending for an outpatient procedure

The second individual we spoke to was attending the hospital for a diagnostic test that required a full bladder. Due to delays, he approached desk staff to ask how long he would need to wait, explaining that he was desperate to use the bathroom. After confirming the nature of his appointment, staff told him it was safe to void his bladder. However, immediately after doing so, he was called for the test and informed by the consultant that he needed to complete a flow test, requiring a full bladder once again. When we met him, he was in the restaurant, having been sent to drink fluids containing sorbitol to rapidly refill his bladder.

He expressed his frustration, as the delay and miscommunication were adding several extra hours to his visit and forcing him to take more time away from work than he had planned. He was particularly annoyed as he had specifically asked whether he should wait before using the bathroom.

Friends of an elderly inpatient

We spoke with friends of an elderly patient - both retired NHS nurses - who were keen to share their observations. They noted that although signage indicated the patient was hard of hearing, staff were unaware he used hearing aids and had to check his property list before locating and fitting them. They also highlighted that, despite the patient being admitted following a fall, there was no falls bracelet or other visible signage in place to alert staff to this risk.

While they spoke positively about staff being helpful and informative, they were concerned that no one had checked who they were, despite them being given detailed information about the patient's condition and care. They felt the ward was short-staffed, describing a 1:5 nurse-to-patient ratio on a frailty ward as "unmanageable," as one nurse being occupied often meant other patients were left without support.

The friends were also confused by changes to the patient's end-of-life status. They explained that he had initially been placed on the end-of-life register but were later told this had been removed, without a clear explanation for the change.

The restaurant is well used by staff, creating a busy and lively atmosphere. However, this means there is limited space for visitors, particularly at peak times. For families—especially elderly visitors—this can make the environment less comfortable when they are waiting for updates about loved ones. Family members accompanying patients for diagnostic procedures reported that they are not able to wait near where the procedure is taking place and often have no designated waiting area nearby. As a result, many end up in the restaurant by default, even if this is not their preferred choice.

Two people we spoke with were using the restaurant simply because they live locally and have no other café within walking distance. Both commented positively on the warmth of the staff and the quality of the food.

We noted the use of single-use plastic cups for water within the restaurant. We wondered why reusable, washable, or paper alternatives were not being used, as this practice does not support the hospital's Green Agenda.

7a Common themes

Staff kindness and commitment

- Across all wards, staff were consistently described by patients and relatives as kind, caring, and committed.
- Even where concerns were raised, individual nurses, healthcare assistants, and support staff were frequently praised for their professionalism and compassion.

Perceived staff shortages and workload pressures

- A strong and recurring theme was that staff are extremely busy and stretched.
- Patients felt there were insufficient staff on wards, limiting time for conversation, personal care, mobility support, and reassurance.
- There was concern that when staff were occupied with one high-need patient, others were left without support.

Impact of staffing on personal care and dignity

- Some patients reported that personal care was basic rather than holistic, with limited opportunities for showers, dressing, or assisted mobilisation.
- Bedbound patients and those requiring multiple staff for care felt this most acutely.

Communication challenges

- Communication was a recurring concern, particularly around:
    - Discharge processes and timings
    - Medication changes or reviews
    - Updates to relatives
- Patients and families often felt uncertain about what was happening and what to expect next.

Medication management and understanding

- Many patients had pre-existing conditions and brought medications from home.
- There was inconsistency in how medications were stored, administered, or self-managed.
- Several patients reported confusion or poor communication about medication changes, missed doses, or responsibility for administration.

Environment, maintenance, and ward conditions

- A clear contrast was noted between newer areas (e.g. Maple Unit) and older wards.
- Older wards were described as tired, run down, and in need of maintenance, with issues including flooring, lighting, walls, ceilings, and storage.
- Cleaners were observed to be working hard, but overall environments were often felt to need "some TLC."

Signage, visibility of information, and consistency

- Bedside information, whiteboards, and signage varied significantly between wards.
- There was limited or inconsistent use of symbols for dementia, hearing impairment, falls risk, or communication needs.
- Patients who were hard of hearing or living with dementia were particularly affected by this lack of visibility.

Boredom, isolation, and lack of stimulation

- Many patients described boredom due to a lack of TVs at the bedside and limited access to day rooms.
- Lean staffing meant assistance to leave beds or wards was not always available.
- Elderly patients were especially affected, often having few visitors due to transport difficulties.

Challenges for people living with dementia

- Mixed wards of patients with and without dementia sometimes caused distress.
- Limited dementia-friendly signage and inconsistent observation were noted.
- Families and visitors highlighted the need for clearer communication and greater awareness of non-verbal needs.

Temperature, lighting, and comfort

- Ward temperature and lighting were frequent points of comment, particularly where wards were felt to be overly warm or brightly lit at night.
- These issues were seen as impacting comfort, rest, and recovery.

Visitor access and facilities

- Visitors faced challenges due to:
    - Limited public transport access

    - Restricted visiting during outbreaks
    - Lack of seating and space in public areas, including the restaurant
- Elderly partners and carers were particularly affected.

Overall patient experience

- Despite environmental, communication, and staffing challenges, the most consistently positive aspect of patients' hospital experience was the attitude and care shown by staff.
- When asked what was positive about their stay, helpful and caring staff were mentioned most often by patients and their families.

8 Recommendations

Following our time speaking with patients and observing staff on eight hospital wards, we have the following recommendations:

1. Improve communication and information sharing

- Strengthen communication with patients and relatives around discharge planning, including clearer explanations of likely timescales and next steps.
- Introduce more consistent daily updates for patients and families, particularly for those with longer stays or complex needs.
- Ensure patients are informed clearly about medication changes, reviews, and responsibility for administration, especially where patients bring medicines from home.
- Encourage staff to speak directly to patients (including children and people with communication needs), not only to relatives or carers.

2. Standardise bedside information and signage

- Implement a consistent hospital-wide approach to bedside whiteboards and patient information.
- Introduce clear, visible symbols for:
    - Dementia
    - Hearing impairment
    - Falls risk
    - Interpreter or communication needs
- Ensure all staff are trained to recognise and respond to these indicators.

3. Address boredom, isolation, and wellbeing on Wards

- Increase opportunities for supported mobility and time out of bed, where clinically appropriate.
- Consider volunteer-led or activity-based support to reduce isolation, especially for elderly patients with few visitors.

4. Enhance personal care and dignity

- Review staffing models and ward routines to ensure patients are offered showers, assisted washing, and help to get dressed, not just essential care.
- Provide additional guidance and training for staff supporting patients with intimate care needs, to reduce discomfort and embarrassment.
- Prioritise dignity-focused care for bedbound and high-dependency patients.

5. Improve medication safety and clarity

- Clarify hospital policy on self-medication versus staff-administered medication, and ensure this is consistently applied.
- Ensure all brought-in medications are checked, documented, and securely stored on admission.
- Strengthen processes to prevent missed or delayed doses, particularly for time-critical medications such as pain relief, inhalers, and thyroid medication.

6. Improve the physical environment

- Ensure call bells, over-bed tables, and bedside storage are consistently available and accessible.
- Review ward temperature controls, particularly in areas reported as overly warm.

7. Strengthen dementia-friendly practice

- Increase dementia-friendly signage throughout the hospital, starting with toilets and bathrooms.
- Review ward mixes where patients with and without dementia are cared for together. Make better use of the dementia nurses in these instances.
- Support staff to better observe and respond to non-verbal cues from patients living with dementia.

8. Support visitors and families

- Ensure ward phones are answered reliably, or introduce alternative ways for families to receive updates when they cannot be present.

9. Build on staff strengths

- Recognise and celebrate the compassion and commitment consistently shown by staff.
- Explore ways to protect time for staff–patient interaction, even brief conversations, as these were highly valued by patients.
- Consider whether staffing models allow sufficient flexibility to meet emotional as well as clinical needs.

8.1 Examples of best practice

Ward 3 has emojis / picture symbols at the bedsides, clear information of patient needs, staff of all disciplines were aware of meanings.

If this were made a hospital wide protocol, all staff would be transferable, no additional training, no confusion, and bank staff would have the same process on all wards.

9 Service provider response

MKUH Response to Healthwatch Recommendations

Thank you for your Enter and View visit on **27 November 2025** and the comprehensive report outlining patient and visitor experiences across eight wards and the hospital restaurant. We welcome your balanced feedback, which reflects both the strengths of our staff and the opportunities for improvement across our inpatient areas.

We are particularly pleased to see consistent recognition of staff kindness, professionalism, and compassion during a period of significant operational pressure. Your findings align with our internal assurance work, and we have used your recommendations to refine and strengthen an integrated, Trust-wide improvement plan spanning Medicine, Surgery, and Paediatrics.

Below is MKUH's updated, aligned response to each Healthwatch recommendation.

1. Improve Communication and Information Sharing

Healthwatch Recommendation: Strengthen communication around discharge plans, medication changes, and day-to-day updates.

Our Response & Actions
• Implementing structured daily updates for patients and families during ward board rounds, including predicted discharge dates.

• Embedding the **'Discharge Ready'** form and beginning discharge conversations at admission.

• Strengthening the clarity of communication regarding medication changes, administration responsibilities, and storage.
• Improving access for families by embedding ward clerks and reviewing alternative communication methods, particularly for relatives unable to attend in person.

• Updating patient-facing resources including Joint School and MyMobility in surgical pathways.

2. Standardise Bedside Information and Symbols

Healthwatch Recommendation: Ensure consistent use of bedside whiteboards and needs-based symbols.

Our Response & Actions
• Trust-wide patient bed boards have been commissioned and will be implemented by **March 2026**.

• These boards include symbols for dementia, hearing impairment, communication needs, allergies, mobility status, and falls risk.

• The new standard will be embedded into induction for permanent temporary staff.

• Communication-needs posters have already been implemented in Paediatrics, with rollout across adult wards underway.

3. Reduce Boredom and Isolation Through Improved Activity and Mobility
Healthwatch Recommendation: Increase stimulation and mobility opportunities.

Our Response & Actions
• Relaunching the Trust-wide **'Get Up, Get Moving'** initiative, in partnership with Therapy and Frailty Teams.

• Auditing day rooms and wards to ensure access to TVs and activity resources, with findings integrated into audits.

• Enhancing mobility and engagement support through Voluntary Services.

• Paediatrics will incorporate a 48-hour play assessment and updated activity information in patient leaflets.

Enhance Personal Care and Dignity

Healthwatch Recommendation: Ensure patients receive holistic personal care and support.

Our Response & Actions
• Reinforced expectations around assisted washing, dressing, and mobilisation through ward-level huddles and senior nursing oversight.

• Therapy-led assessments continue to support dignity, mobility, and independence.

• Ward leaders have been asked to prioritise dignity-focused care in staffing decisions and escalation plans.

5. Improve Medication Safety and Clarity
Healthwatch Recommendation: Ensure clear, consistent processes for medication administration and self-medication.

Our Response & Actions
• Conducting a Trust-wide review of the self-medication policy, supported by an audit of current practice.

• Strengthening processes for brought-in medicines, including clearer communication with patients on storage and administration.

• Reinforcing timely analgesia administration and monitoring this through audit and daily huddles.

• Ensuring staff explain any medication changes promptly and clearly.

6. Improve the Physical Environment

Healthwatch Recommendation: Address environmental maintenance issues and ensure essential equipment is available.

Our Response & Actions
• Working with Estates on refurbishment programmes for wards (**2B, 3, and 17**, with business cases already approved).

• Reviewing temperature control, lighting levels, and environmental comfort, including introducing night-lighting in paediatrics.

• Increasing toilet cleanliness checks and improving escalation processes for facilities concerns.

• Ensuring consistent availability of lockers, over-bed tables, and safe storage across wards.

7. Strengthen Dementia-Friendly Practice

Healthwatch Recommendation: Improve dementia-friendly environments, signage, and staff knowledge.

Our Response & Actions
• Rolling out dementia-friendly signage across wards, starting with bathrooms and toilets.

• Continuing targeted dementia training for staff, prioritising frailty and high-risk wards.

• Dementia Specialist Nurses are supporting wards with mixed patient profiles and strengthening observation of non-verbal cues.

• Estates are reviewing future refurbishments to incorporate dementia-friendly design principles.

• MKUH continues active participation in the **ETOC (Enhanced Therapeutic Observation & Care) programme**, improving therapeutic care for patients with cognitive impairment.

8. Support Visitors and Improve Access to Information

Healthwatch Recommendation: Ensure relatives can reliably receive updates and access waiting areas.

Our Response & Actions
• Reviewing responsiveness of ward telephones, with focused support for ward support staff.

• Exploring alternative ways for families to receive updates, including structured callback systems and digital options.

• Considering improvements to waiting area facilities, particularly for relatives attending diagnostic procedures.

9. Improve Catering Access and Dietary Support

Healthwatch Recommendation: Improve menu clarity and ensure dietary needs are met.

Our Response & Actions
• Reviewing menus for children with intolerances and ensuring clearer information is available to staff and families.

• Expanding menu variety for long-stay adult patients.

• Standardising dietary abbreviations trust-wide to prevent misunderstandings.

10. Address Staffing Pressures and Build Workforce Resilience

Healthwatch Recommendation: Ensure staffing levels support safe, dignified care.

Our Response & Actions
• At the time of the visit, MKUH was operating at **OPEL 4**, with high acuity driving pressure rather than unfilled shifts.

• The Trust maintains three daily safe-staffing meetings, supported by SafeCare data, Divisional Matrons, and Ward Managers.

• Staff can escalate concerns through real-time digital **Red Flag** reporting.
• MKUH completes twice-yearly staffing establishment reviews using the **Safer Nursing Care Tool** and compliance with **Developing Workforce Safeguards** and **National Quality Board** standards.

• Actions include supporting clinical areas with redeployment, oversight, and targeted interventions during high-pressure periods.

Next Steps
• All actions have been incorporated into the Trust governance plans and will be monitored through Divisional and Trust-wide assurance processes.

We deeply value your contribution to improving patient and family experience and look forward to continued partnership.

Yours sincerely,
Joe Harrison
Chief Executive Officer

Engage-Share-Inspire CIO
Healthwatch Milton Keynes
Room 1-2, The Vaughan Harley Building
The Open University Walton Hall Milton
Keynes, MK7 6AA

www.healthwatchmiltonkeynes.co.uk
t: 01908 736005
e: info@healthwatchmiltonkeynes.co.uk

Facebook.com/Healthwatch_MK
Instagram: Healthwatch_M