

Royal Cornwall Hospitals NHS Trust

Quality Report

Treliske
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This report describes our judgement of the quality of care at this trust. 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 trust

Are services at this trust safe?	
Are services at this trust effective?	
Are services at this trust caring?	
Are services at this trust responsive?	
Are services at this trust well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in the county of Cornwall. The Trust is not a Foundation Trust and performance is monitored by NHS Improvement (NHSI). The Trust serves a population of around 415,783 people, a figure that can be doubled by holidaymakers during the busiest times of the year.

CQC has previously carried out two comprehensive inspections at Royal Cornwall Hospital NHS Trust. The first being in January 2014 when the Trust was rated as requires improvement. In June 2015 we carried out a follow up to the first inspection and found the trust had not made sufficient progress in all areas and a second comprehensive inspection was initiated, which we carried out in January 2016. At that time, the trust was rated as requires improvement overall. We rated safe, effective, responsive and well led as requires improvement and caring as good.

This inspection was a responsive, unannounced focused inspection and was conducted on 4 and 5 January 2017. We reviewed end of life and urgent care services to review progress against the inadequate ratings for those core services as identified on the previous inspection in January 2016. We reviewed medicine services as continued intelligence had raised concerns with regards to quality and safety of the service. We also looked at the governance and risk management support for the services we inspected. On 2 March 2017, we returned to the trust to review the fit and proper person's process. This was announced to the trust the day before we attended.

Only those services provided at the main Royal Cornwall Hospital site in Treliske were inspected. We did not inspect:

- St Michaels Hospital
- West Cornwall hospital
- Penrice birthing unit

We did not rate Royal Cornwall Hospitals NHS Trust overall at this inspection because we only reviewed three core services and well led at provider level, and because the previous inspection was more than 12 months earlier.

Key findings:

Safe:

- There was a system in place for capturing incidents, however the system was not being used in a reliable way, and the processes around incident reporting were not robust enough, or implemented in terms of identifying, capturing, reporting or reviewing incidents. Although staff did complete incident forms and they were encouraged to do so, there was little evidence of actions or learning resulting from these.
- The classification of incidents was not effective, for example we found multiple examples of incidents (where harm had resulted) classified as 'no harm'. This meant not all incidents were investigated or escalated appropriately, and opportunities to learn and improve were missed. It also meant that the trust were not able to produce accurate reports for analysis or accurately identifying risks or trends, for example, there was no reliable process for establishing which incidents related to end of life patients.
- Not all incidents had action plans associated with them, and those that did, were not always robust or monitored to ensure they had been completed, and learning had taken place.
- As the level of harm had not always been correctly established or recorded, there was no assurance that duty of candour had always been applied appropriately.
- There was inconsistency with the quality of serious incident investigation reports and evidence of learning from patient deaths. There was no evidence to show actions identified following serious incidents were reviewed for progress and led to improvements. In addition, we found examples of serious incidents that had not been reported as such.
- In some medical wards there were known staff shortages. However, the trust assured us that detailed meetings took place across the day to ensure the safe staffing of wards. Some staff told us that the process for booking agency staff was complicated.
- Neurology did not have sufficient staffing capacity to provide a seven day service.
- The number of consultants in the emergency department and the hours they worked were below recommended levels, although there was active

Summary of findings

recruitment, and good coverage from junior doctors. The overcrowding in the department meant there were times when the nursing staff levels were not adequate. Levels of nursing staff were rising towards planned numbers, but staff raised concerns about cover in the minor injuries' area at night being adequate.

- The specialist end of life team did not have enough medical or nursing staff to provide a service seven days a week and cover arrangements were limited. However, specialist advice on end of life medicines to treat pain and other symptoms was available to any clinical staff 24 hours a day, seven days per week.
- An electronic alert system set up to notify doctors of patients needing to be seen meant that on occasion, doctors were inundated with messages and updates which meant they found it hard to prioritise patients.
- The Trust had set itself a challenging 100% target for Safeguarding training. Although there had been an increase in compliance rates, there were still some areas where compliance remained low. In some ward areas less than 50% of the staff were sufficiently trained in children's safeguarding. Training for both adult and children's safeguarding was not meeting trust targets.
- Many consultants did not have the required levels of mandatory training to keep people safe. Insufficient numbers of consultants had training in infection control, manual handling, fire safety, health and safety or information governance. Nurse mandatory training was much improved in the emergency department and coming up towards targets. There was an impressive length of time given over to nurse mandatory and continuous developmental training.
- There was inconsistent understanding across wards regarding which nursing staff had in date syringe driver training and competency to safely set up and monitor equipment. This had been raised during the last inspection, but progress was not apparent.
- There was no up-to-date record of review of equipment skills for staff in the emergency department, and a number of pieces of equipment were indicating they were overdue for servicing.
- Resuscitation trolley checks on the Medical Admissions Unit and Tintagel ward were frequently missed which meant that there was an increased risk to the patient if the equipment was needed.
- The overcrowding in the emergency department was causing reduced access to some areas, including the resuscitation room. Emergency evacuation may also be impeded.
- Not all patients were able to reach their call bells. These were not provided in some areas, or within patients' reach in others.
- We found that medicines were not stored securely in the Medical Assessment Unit and despite raising our concerns found that medicine security got worse as the inspection went on.
- There were delays in medicine administration which had not been resolved. There were two incidents during our inspection of a lack of security with the drug cupboard keys. There were some issues with medicines' management and storage in some areas, although this was mostly well managed.
- There had not been a sustained improvement in the timeliness of observations, and management of sepsis in the emergency department.
- There was still further progress to be made, but a much improved assessment and response to patient risk, triage and urgent treatment, although not all patients were receiving a timely electrocardiogram (ECG) test when presenting in the emergency department with chest pain.
- Risks to people who used end of life services were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviours that challenged. The specialist end of life team and ward staff reviewed end of life patient care every day in order to respond to changeable conditions and risks, although improvements were required to how treatment escalation plans were completed by doctors to ensure compliance with policy.
- Although infection control practices were generally good they were unsafe on the Medical Admissions Unit. Not all cleaning of equipment was recorded in the emergency department.
- We observed a lack of hand hygiene at times among the staff in the emergency department.
- There was a variable level of completion of emergency department patient records from comprehensive to poor, although audit work in the department demonstrated this was improving.

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- On regular occasions on the medical wards we found that records trolleys were left unlocked and unoccupied. We also found zip locked bags containing records left unattended by the ward entrances awaiting collection.

Effective:

- The Royal College of Emergency Medicine audits were not given a satisfactory priority in the year in which they were to be undertaken. The results of the asthma audit were poor although they had used an insufficient dataset, and the audit was done outside of the required period. The emergency department had however, excelled in the timeliness, care and treatment of patients suffering a stroke or trauma.
- We asked for, but were not provided with up to date audit information for some national audits. The results of these in the previous inspection were worse than the national average. However, we saw that there had been improvement in the national stroke audit. The trust had gone from a level E to a level D, which is the national average.
- There was a lack of ongoing audit information to evidence quality and progress in the delivery of effective end of life services. End of life service did not participate in any national audit.
- There was evidence that people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- During December 2016 a revised end of life strategy and patient care documents were launched based on national guidance. The strategy lacked accompanying staff training and emphasis to ensure all doctors understood what their roles and responsibilities would be.
- Whilst new end of life care plans were being rolled out across the trust, there remained a lack of recorded evidence to show end of life care provided was holistic and person centred. There was a reliance on the patient or relatives of the patient initiating and articulating any personalised wishes in order for any actions to be taken, and documentation did not always reflect this to ensure patients were safe at all times.
- A continuously funded secondment post for generic hospital staff to work with the specialist end of life team to increase their skills and knowledge was available but not fully utilised.
- There was little evidence of advance end of life care planning being undertaken. Most of the staff we spoke with did not recognise end of life as relevant during the last twelve months of life.
- In medicine, there was evidence people had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- Discharge was not done in a timely way and there was not robust multi-disciplinary working around discharge. All patients were subject to standards set in the SAFER care bundle. Achievement in standards of discharge was significantly lower than the trusts target. Examples of these targets included the timeliness of discharge and discharge on the patient's clinically stable date. Staff told us this was due to delayed transfers of care and delays with external assessments.
- There was no seven day consultant cover for neurology patients. This increased the risk to patients at weekends. The use of a consultant of the week model had an impact on the effectiveness of treatment. Staff were not supported well and patients were missing important medicines as a result of a lack of accountability under this model. The end of life service did not provide seven day services, and there was limited out of hours cover. All services needed to provide effective care were available seven days a week in the emergency department.
- The link end of life care meetings were a productive forum for learning and sharing clinical and policy updates and were valued by those staff who attended.
- Records maintained by the specialist end of life team showed they were prompt to respond to referrals, although these were increasing and staff were already stretched. Staff throughout the hospital told us they understood how to contact the team and highly valued the expertise, guidance and support provided.
- There was a strong ethos in the emergency department for multidisciplinary working and we saw some good examples of this. When people received

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care from a range of different staff, teams or services, it was coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment.

- Many consultants did not have the required levels of mandatory training to keep people safe. Very few consultants had training in infection control, manual handling, fire safety, health and safety or information governance. In the emergency department, staff had the right competencies, experience and skills and professional development and competency training had improved. There was an excellent range of training for medical staff, including outstanding simulation training and production of high-quality case studies, teaching materials, guidance and protocols.
- Appraisal rates in medicine were not meeting targets. Only two wards had appraisal rates higher than the 95% trust target. Some wards were significantly lower with Kerensa ward having 56% compliance and Tintagel ward having 65% compliance. In the emergency department, staff appraisals had improved and were heading towards target.

Caring:

- Feedback from patients and those close to them was mostly very positive about the way staff treated people. People were treated with dignity, respect and kindness during their stay.
- People are involved and encouraged to be partners in their care and in making decisions. Staff spend time talking to people, or those close to them and we witnessed staff in the emergency department at a very busy time, taking care to help patients understand what was happening to them.
- Staff had the skills and compassion to communicate effectively to patients during times of distress. This was particularly apparent in the coronary care unit, and in the emergency department.
- Feedback was overwhelmingly positive on Wellington ward. Staff were enthusiastic about the care they were giving. Patients felt that staff went the extra mile and exceeded their expectations.
- Patients and their relatives told us they had been consulted about end of life treatment and care, this was also evidenced in some of the care plans we reviewed, although there was a lack of detailed written information in care records to show what had been

discussed with patients and how they had been included and involved in treatment and care. This meant that when staff changed shift, these needs would not always be clear.

- The new cancer resource centre provided a wide range of resources, counselling and support to any person affected by cancer.
- Friends and Family response rates were not good across the medicine directorate. For example on Carnkie ward, Tintagel ward and Kerensa ward response rates were below 10%. In the emergency department, although improving the response rate was also very low, but the trust was recommended, in those responses received, by a higher number of people than the England average. For end of life care, there was a lack of survey or other evidence to show patients' needs were being consistently met.
- Due to overcrowding in the department, it was difficult to avoid breaches of privacy and dignity for some patients.

Responsive:

- Although processes were in place to support flow within the hospital there were not enough beds to meet the demand of the service. Bed capacity was full and escalation areas (such as theatres and day case surgery) were regularly being used. Additionally there were 40 medical outliers in surgical wards. This took up 16% of the surgical bed base. On the day of the inspection the trust had sought external help and support by the use of escalation (Gold Call) to address the system risk and attempt to reduce bed occupancy.
- The emergency department had moved up the national rankings in terms of accident and emergency target waiting times, and the time taken to first treat patients was consistently better than the standard of 60 minutes, with care and treatment appropriately prioritised. However, demand on the service and the way it had been required to operate meant too many patients were, at times, waiting on trolleys to be admitted to a ward, and flow was not timely; the department had not met the target to admit, discharge, or transfer 95% of patients within four hours for at least the last two years. At the time of our inspection, this was running at around 77%. People in the emergency department were kept informed about waiting times and alternative access to treatment in the county.

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- People were frequently and consistently not able to access services in a timely way due to the over occupancy and the issues with flow. This included delays for an initial assessment, diagnosis or treatment and people experienced unacceptable waits for some services. During the inspection over 100 patients were delayed in hospital due to inability to access community services. Between April 2016 and December 2016 over 1700 bed days were lost as a result of inadequate hospital flow. This was a worsening picture since the last inspection.
- On average 97 patients a month were waiting longer than seven days for discharge. This increased the risks of patients deteriorating, prevented patients who required medical care accessing wards, and caused crowding in the emergency department. An external agency had recently undertaken a comprehensive review of the discharge systems and processes and work had been initiated to implement their recommendations.
- Staff in the end of life service told us discharge delays were frequent and resulted from a lack of community resources. There was no information to evidence this. Whilst there were issues regarding the availability of community resources, there were no apparent plans in place to address these issues with community providers in order to make service improvements to meet patients' discharge needs. In some areas there was confusion regarding who had overall responsibility for processing fast track patient discharges through to discharge.
- There was a waiting list for cardiac procedures within the hospital with some patients not being seen by their 'see by' date, due to staff capacity and cancellations of clinics. There was evidence to show this had been getting worse over time, and since the last inspection. However, we were informed of the Trust's active work plan to recruit more staff and the oversight of the risk in Cardiology.
- There was a lack of processes in place to evidence if the end of life care provided was responsive to patient's needs and wishes. Ward staff primarily relied on the patient or relatives to initiate and communicate any requests.
- There was inconsistent feedback and evidence to show if patients spiritual and cultural needs had been reviewed and any needs addressed. Patient's personal choice as to where they preferred to receive their end of life care was not routinely monitored and reviewed.
- The medicine and emergency department services were planned to meet the needs of local people. People using the service could all do so on an equal basis. We found that some reasonable adjustments had been made to manage the needs of patients with individual vulnerabilities. This included patients living with dementia and patients with a learning disability. We found that there had been significant improvements in the stroke service which ensured that the design of services were tailored to meet their needs.
- The cancer resource centre provided a wide range of services, support, training and information based on the needs of patients and people close to patients. The centre also provided training information and information for trust staff and other professionals who provided any services to patients with cancer.
- Complaints in medicine were not being handled in a timely way and in all areas, there was insufficient evidence to show complaints led to changes and improvements.
- A third of complaints in medicine were resolved beyond their timescales. However, we found that it was easy for patients to raise a concern or a complaint. There was openness, transparency, and a will to learn from complaints on the wards, although this learning was not shared more widely. We found examples where learning from complaints had resulted in changed practice locally.
- There had been a drive for the complaints team to hold early resolution meetings with complainants, and these had resulted in fewer complaints progressing through to formal complaints.

Well led:

- Although staff understood what the vision and values were, they felt they were not able to fully live by them due to the pressures of the job.
- Strategic objectives were aligned to a degree to the vision and values, however due to ongoing work and involvement with the county's sustainability and transformation plans, the detail underpinning the strategic aims had not yet been formulated or

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articulated, and staff across all areas we visited were unsure of the impact this would have on their roles and services. Service level strategies were at different stages of development.

- Recommendations from an external governance review undertaken in July 2015 had been accepted, but progress in implementing the changes had been limited, and the governance arrangements currently in place were unclear.
- There was confusion around senior leader's accountability portfolios which had yet to be formally agreed, and below board level, the subcommittee and divisional reporting structures were not clear. Some governance committees had been suspended due to operational pressures.
- The processes in place to meet the Fit and Proper Persons Requirements for Directors (FPPR) were not sufficient to meet the requirements of the regulations and did not provide appropriate assurances that adequate checks were being made and recorded to confirm directors were suitably 'fit and proper'.
- Reports to the board did not consistently set out the key issues or risks facing the services, and some areas had not reported as expected, or at all during 2016 due to capacity, for example, end of life services.
- There was concern about the level of oversight, challenge and scrutiny at board level and assumptions being made that sufficient scrutiny occurred at subcommittee level, which some leaders told us, it did not.
- The risk registers that were in place at the time of the inspection did not accurately reflect the risks to patient safety and the quality of care and treatment. The corporate risk register similarly did not reflect all known risk and appropriate mitigations. There was confusion around the newly reset risk tolerances, which had not been documented.
- There was no effective assurance system in place for identifying, capturing and managing risks between ward and divisional level. There was no assurance that risks were being escalated and actioned appropriately. There was a lack of capacity to recognise and respond proactively to emerging risks given the focus on urgent priorities. There was some confusion as to who had ownership of incidents and risk between the central team and the divisions, and the divisional teams did not always have the required access to manage their incidents.
- The emergency department risk register had few clinical risks; concentrated on mostly potential environmental risks; and beyond the ongoing situation with crowding, did not address known or current concerns. The end of life service did not have a specific risk register.
- Safety and quality meetings at divisional level were of a variable standard. Whilst all departments indicated the occurrence of meetings, some departments demonstrated a lack of escalation. It was also reported by staff in some divisions that the escalation of issues was futile, with little recognition, feedback or action from executive level meetings.
- There was not a holistic approach to the monitoring of safety and performance data, supported and informed by robust, ongoing clinical audits in all services underpinned by robust action plans to drive improvements. There were a number of areas not being considered through this mechanism, or not demonstrating sufficient priority, for example the RCEM audits.
- There was a lack of audit and quality measures to fully evidence quality and risk management issues for end of life patients to maintain and make service improvements. There was no routine engagement with patients or those people close to them to gather feedback in order to make service improvements.
- Quality improvement was not embedded across the organisation.
- There was a conflict between delivering high quality patient care, and the time to commit to good governance and risk management. Operational pressures compounded this.
- Available funds and training available for the development and sustainability of a skilled end of life workforce throughout the trust had not been fully utilised.
- There was an established pattern of increased referrals to the specialist end of life team but there were no plans in place to ensure the team who were already stretched, had the capacity to cope with it.
- The issues identified in the core services inspected and the lack of significant and sustained progress since the previous inspection raised questions about the capacity and capability of the trust leadership team. There has been a prolonged period of instability at board level, and some evidence to show this has impacted on patient care and staff morale. There was

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widespread anxiety about the effect and impact of the sustainability and transformation plan (STP), and the potential dilution of leadership with the chief executive spending more time in her role as lead officer for the STP.

- There was a lack of support from the wider system which led to delays in the management of key risks, such as patient flow. Leadership of the end of life service was not fully effective and coordinated.
- In medicine, there were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported and appreciated. This was particularly apparent on Tintagel ward. More work was needed to improve the continuing poor staff engagement and staff survey results.
- All staff we met were focused to continually improve the care they were giving. This was particularly apparent on Wellington ward where innovate schemes had been introduced to develop skills further.
- The specialist end of life team was held in high regard by staff we spoke with on the wards and other services we visited, and in the emergency department, there was experienced, committed, caring and strong local leadership. The leaders understood the challenges they faced and had ambitions for improvements and innovation. Staff in the emergency department felt respected and valued. There was encouragement of openness, candour and collaborative working.

We saw several areas of outstanding practice including:

- There was an outstanding commitment to medical simulation training in the emergency department and this extended to the production of detailed and valuable case studies. This provided education for staff, but also awareness of human factors in a busy environment, and how staff might react to those.
- There had been an outstanding response to trauma and stroke patients in the emergency department. The department was among the top hospitals in the country for providing timely and appropriate care.
- There was an outstanding commitment to mandatory training for the nursing staff in the emergency department with three-day sessions held to cover this and other key topics for continuous professional development.
- Despite unprecedented overcrowding, the emergency department was calm and professional during our unannounced inspection.

- MASH up Monday training on Wellington ward – this was small training sessions on the ward led by the ward sister and other relevant staff and was being extended to cover something each weekday. The ward sister had won a trust pride and achievement award in November 2016 for this.
- Clinical Matron for the cardio-respiratory directorate was nominated for a Nursing Times award for 'Matrons Rounds' – promoting safe, effective, caring, responsive and well led care in January 2016.
- One of the respiratory doctors had organised a respiratory day for staff at an external venue that included training, lunch and discussion about respiratory care. The matron said the doctor was very enthusiastic and staff were looking forward to the day.
- The use of an electronic pharmacy system to ensure detailed exchanges of communication to community GP's and pharmacists. This ensured that the community teams were up to date in dose changes, new medicines, discontinued medicines, and those that were to continue but were temporarily stopped.

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

Importantly, the trust must:

- Review, document and implement the governance processes, subcommittee structures and reporting lines to and from the board and ensure this is communicated to staff.
- Review the governance in the emergency department and across medicine to ensure it has evidence that recognises and addresses risks, safety, and quality of care. This needs to include actions from avoidable patient harm, progress with audits, and demonstrable learning and improvements when there are incidents, complaints, and other indications of emerging or existing risks.
- Review and improve governance processes to fully evidence all quality and risk management issues for end of life patients, and ensure these are reported in line with the risk management policy and processes.
- Review and implement the systems and processes for managing corporate, divisional and local risk registers and ensure that all staff are clear about their roles and

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responsibilities. The risk register must be improved to recognise all risks, particularly clinical risks, and consider where there are gaps in what is reported and how they are reviewed.

- Review the incident reporting systems and processes and provide assurance this is a fair reflection of the risks in the trust at all times. Ensure any categorisation of an incident is accurate in order to ensure learning and appropriate escalation from all incidents, including 'near miss' events. In addition, to ensure that duty of candour is correctly applied in all cases.
- Review how end of life patient care is captured within the trusts incident reporting system to ensure incidents reported in all categories can adequately identify if they also involve end of life patients, and improve and educate staff trust wide to recognise what end of life issues could or should be reported as an incident.
- Present incident information with more prominence in safety reviews and governance committees with a responsibility for risk, and embed and demonstrate learning and improvement.
- Address timeliness and inconsistencies in the quality of investigation reports for all serious incidents.
- Demonstrate learning across the trust from patient deaths, particularly, but not limited to, any that were unexpected or avoidable.
- Ensure that actions to improve on performance measures are robust, are actioned appropriately and are discussed at the relevant meetings to ensure senior level and board oversight as necessary.
- Ensure a holistic approach to the monitoring of safety and performance data, supported and informed by robust, ongoing clinical audits in all services underpinned by robust action plans to drive improvements.
- Ensure that staff receive appropriate safeguarding training to protect both adults and children.
- Ensure that both nursing and medical staff have appropriate mandatory training to keep people safe.
- Continue to review and put in place measures to address and manage patient access and flow, and ensure patients are appropriately discharged, working closely with system partners to achieve workable solutions to the current barriers, including a review of the effectiveness of system wide GOLD calls and the steps taken in advance of anticipated busy periods to plan for this.
- Ensure that designated leaders have the time and capacity to lead effectively and manage governance within their divisions, departments and teams.
- Review using the emergency department as an access point for medically expected and surgical patients to relieve pressure on the whole system, reduce breaches of patient privacy and dignity, and improve the response to patients.
- Ensure that there is appropriate medical oversight and accountability for neurology patients on Tintagel ward including at weekends.
- Find a workable solution to delays in the administration of medicines to patients in the emergency department, and ensure that medicines in the medical division are stored safely and securely.
- Ensure there is a sustained and effective improvement in the management of sepsis in the emergency department.
- Ensure there is evidence in the emergency department of governance for equipment and the environment, which includes staff competence, cleaning regimes, availability of call bells in all areas, and maintenance being undertaken when required.
- Ensure that resuscitation trolleys in the medical division are checked appropriately so they are safe to use.
- Ensure that medical records remain secure and locked away throughout the medical division.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospitals NHS Trust provides care to around 415,783 people across Cornwall, which can increase twofold during holiday periods. This includes general and acute services at Royal Cornwall Hospital, elective surgery at St Michaels Hospital, day surgery, medicine and renal services at West Cornwall Hospital and maternity services at Penrice unit at St Austell Hospital. CQC only inspected the main Royal Cornwall Hospital site during this unannounced focused inspection.

At the time of the inspection and over the last few years, there had been a significant and ongoing period of instability at board level. Since the first inspection in January 2014 there had been three chief executives in post, two of those on an interim basis. A permanent chief executive was appointed in April 2016. A new chair was appointed in 2015 and had since stepped down in August 2016, with an interim chair covering whilst awaiting the start date for the newly appointed chair whose position had recently been confirmed. The director of nursing was

an interim post at the time of the inspection, having been in post since December 2015, and this post was due to end in April 2017, with plans for recruitment to a permanent post underway. An interim medical director was in post since October 2016 for a period of 6-9 months and this post has been advertised externally. Similarly, the chief operating officer post was interim from October 2016, with this post also being advertised externally. The newly appointed director of human resources commenced in post in December 2016, and the director of corporate affairs commenced in post in January 2017. The director of finance was the longest standing executive member of the team having been in post for six years.

This inspection was carried out to follow up on the inadequate ratings for the emergency department and end of life care, and as a result of increasing concerns around the safety and quality of care in the medicine services, from various sources of intelligence.

Our inspection team

Our inspection team was led by:

Chair: Sean O'Kelly, Medical Director, University Hospitals Bristol NHS Foundation Trust

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

Inspection Manager: Julie Foster, Care Quality Commission

The team included seven CQC inspectors and a variety of specialists: a pharmacist, two medical directors, a medical consultant, two senior medical nurses, a senior A&E nurse specialist, a chief nurse and governance specialist, an end of life nurse specialist and an expert by experience.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

- Is it well led?

The inspection team inspected three core services:

- Medicine
- End of life care
- Urgent and emergency care

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We also looked at the governance and risk management arrangements supporting those core services.

Before, during and after visiting, we reviewed a range of information we held about the trust and asked other organisations to share what they knew about Royal Cornwall Hospital. These included the local commissioning group, NHS Improvement (NHSI), NHS England, the local council and we reviewed information from Cornwall Healthwatch.

We carried out an unannounced inspection of the main hospital site only, and we held three staff drop in sessions for a range of staff with various roles and levels of

seniority across the hospital. 50 members of staff came to these sessions to share their experiences. People also contacted us via our website and contact centre to share their experience.

We talked with 64 patients and 205 members of staff from across the hospital, including nurses at all levels, consultants and junior doctors, health care assistants, allied health professionals, chaplains, administrative staff, volunteers, managers and senior leaders. We observed how people were being cared for, talked with carers and family members, and reviewed over 77 patient records, including individual patient care records, patient treatment escalation plans, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms, medical notes, observation charts and pharmacy records.

What people who use the trust's services say

Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at Royal Cornwall Hospitals NHS Trust. Responses were received from 626 patients. The Trust scored significantly better than the national average in relation to 13 indicators, and scored significantly worse in the case of 3 indicators.

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would

recommend the service they have received to friends and family. In the 2015/16 reporting year, the trust received approximately 70,000 responses of which 83% were positive reflections of care and treatment.

However, response rates were not good across the trust, with some areas having a response rate below 10%.

For end of life care, there was a lack of survey or other evidence to show patients' needs were being consistently met.

Facts and data about this trust

Key figures for the Royal Cornwall Hospital:

Local Population:

- Around 415,783 people are served by the trust, although this figure can double during busy holiday seasons
- According to the 2011 Census, Cornwall's population was 98.1% white
- Twenty-three per cent of the population were aged 65 and over
- In the 2015 Indices of Multiple Deprivation, Cornwall was in the second-to-worse quintile for deprivation

- Cornwall performed better than the England averages for 25 of the 32 indicators in the Area Health Profile 2015. Areas where the county performed worse than average included excess weight in adults and incidence of malignant melanoma

Bed capacity and activity:

- 731 general acute beds
- 107,668 general admissions between April 2015 and March 2016 (down 1% on previous year)
- 717,112 outpatient attendances between April 2015 and March 2016 (down 1% on previous year)
- 84,047 A&E attendances between April 2015 and March 2016 (up 6% on previous year)

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Staffing:

- 4,502 whole time equivalent (WTE) staff, comprising 586 medical staff, 1,099 nursing staff and 2,817 categorised as other staff groups.

Revenue:

- Annual operating income was £354,043,000
- Financial deficit was -£6,906,000

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We did not rate the trust overall during this inspection.</p> <p>The team made judgements about three services. Of those, two were judged to be requires improvement and one as inadequate. Therefore the trust was not consistently delivering good standards of safety in all areas.</p> <p>Summary of key findings for safe:</p> <ul style="list-style-type: none">• There was not a reliable or effective system in place to identify, capture, report or review incidents. Although staff did complete incident forms and they were encouraged to do so, there was little evidence of actions or learning resulting from these.• The classification of incidents was not effective, for example we found multiple examples of incidents (where harm had resulted) classified as 'no harm'. This meant not all incidents were investigated or escalated appropriately, and opportunities to learn and improve were missed. It also meant that the trust were not able to produce accurate reports for analysis or accurately identifying risks or trends, for example, there was no reliable process for establishing which incidents related to end of life patients.• Not all incidents had action plans associated with them, and those that did, were not always robust or monitored to ensure they had been completed, and learning had taken place.• As the level of harm had not always been correctly established or recorded, there was no assurance that duty of candour had always been applied appropriately.• There was inconsistency with the quality of serious incident investigation reports and evidence of learning from patient deaths. There was no evidence to show actions identified following serious incidents were reviewed for progress and led to improvements. In addition, we found examples of serious incidents that had not been reported as such.• There were frequent staff shortages across medical wards and the complicated systems to secure agency staff meant that staffing levels in areas fell below safe levels. Neurology did not have sufficient staffing capacity to provide a seven day service.	

Summary of findings

- There were a waiting list for cardiac procedures within the hospital with some patients not being seen by their 'see by' date. This was a worsening picture since the last inspection. However, we were informed of the Trust's active work plan to recruit more staff and the oversight of the risk in Cardiology.
- The number of consultants in the emergency department and the hours they worked were below recommended levels, although there was active recruitment, and good coverage from junior doctors. The overcrowding in the department meant there were times when the nursing staff levels were not adequate. Levels of nursing staff were rising towards planned numbers, but staff raised concerns about cover in the minor injuries' area at night being adequate.
- The specialist end of life team did not have enough medical or nursing staff to provide a service seven days a week and cover arrangements were limited. Referrals were increasing.
- The trust had set itself a challenging 100% target for Safeguarding training. Although there had been an increase in compliance rates, there were still some areas where compliance remained low. In some ward areas less than 50% of the staff were sufficiently trained in children's safeguarding. Training for both adult and children's safeguarding was not meeting trust targets.
- Many consultants did not have the required levels of mandatory training to keep people safe. Insufficient numbers of consultants had training in infection control, manual handling, fire safety, health and safety or information governance. Nurse mandatory training was much improved in the emergency department and coming up towards targets.
- There was inconsistent understanding across wards regarding which nursing staff had in date syringe driver training and competency to safely set up and monitor equipment.
- There was no up-to-date record of review of equipment skills for staff in the emergency department, and a number of pieces of equipment were indicating they were overdue for servicing.
- Resuscitation trolley checks on the Medical Admissions Unit and Tintagel ward were frequently missed which meant that there was an increased risk to the patient if the equipment was needed.
- The overcrowding in the emergency department was causing reduced access to some areas, including the resuscitation room. This meant that emergency evacuation may also be hindered.
- Not all patients were able to reach their call bells. These were not provided in some areas, or within patients' reach in others.

Summary of findings

- We found that medicines were not stored securely in the Medical Assessment Unit and despite raising our concerns found that medicine security got worse as the inspection went on.
- There were delays in medicine administration which had not been resolved. There were two incidents during our inspection of a lack of security with the drug cupboard keys. There were some issues with medicines' management and storage in some areas, although this was mostly well managed.
- There had not been a sustained improvement in the timeliness of observations, and management of sepsis in the emergency department.
- Not all patients were receiving a timely electrocardiogram (ECG) test when presenting in the emergency department with chest pain.
- Improvements were required to how treatment escalation plans were completed by doctors to ensure compliance with policy.
- Infection control practices were unsafe on the Medical Admissions Unit and not all cleaning of equipment was recorded in the emergency department. We observed a lack of hand hygiene at times among the staff in the emergency department.
- There was a variable level of completion of emergency department patient records from comprehensive to poor, although audit work in the department demonstrated this was improving.
- On regular occasions on the medical wards we found that records trolleys were left unlocked and unoccupied. We also found zip locked bags containing records left unattended by the ward entrances awaiting collection.

However:

- There was a much improved assessment and response to patient risk, triage and urgent treatment.
- There was an impressive length of time given over to nurse mandatory and continuous developmental training in the emergency department.
- Comprehensive risk assessments were undertaken, and risks to people were assessed, monitored and managed on a day-to-day basis, with good use of the National Early Warning System (NEWS).
- Infection control practices were generally good in most areas.

Detailed findings

Duty of Candour

Summary of findings

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust had a process in place to fulfil its obligations in relation to the duty of candour regulations.
- There was evidence that the trust was open and honest with patients in the serious incidents we reviewed. Records showed that a formal apology had been given as required, along with an explanation of the actions that would be taken to prevent the issue happening again. In September 2016 a separate field was added to the serious incident template to ensure duty of candour was considered and documented for all serious incidents. However, opportunities to implement the duty of candour may have been missed through the incorrect classification of incidents as 'no harm' where they may have been moderate, major or catastrophic.
- The majority of staff we spoke to were aware of the need to be open and transparent under the duty of candour regulation. The trust had produced staff guidance setting out legal requirements upon them when things went wrong.

Safeguarding

- The Deputy Director of Nursing had delegated authority and was the named lead on the board for safeguarding, providing a strategic steer. As per statutory requirements the Trust had three Named Professionals for safeguarding children, and two for safeguarding adults, along with 15 hours of dedicated secretarial time per week to support the service.
- Since May 2016, the children and adult safeguarding services had been integrated and were co-located in Pendragon House. The trust board received the Safeguarding Adults and Children's Integrated Annual Report in July 2016 from the trust's named professionals for safeguarding which provided a summary and overview of safeguarding activity within the trust over the past year, outlining key achievements and challenges. Training was highlighted as a challenge, and compliance rates for level 1 adult safeguarding training were between 96% and 99%, and for level 2 they were between 65% and 71%.
- The board also received the statutory annual children safeguarding declaration in July 2016, which set out the trust's compliance status. The declaration stated level 1 training was compliant, but did not give any figures or assurance in terms of levels 2 or 3 training, other than to say training compliance continued to be a focus and it was hoped rates would increase

Summary of findings

over the next six months, with the addition of further in-house training. When reviewing compliance rates for children's level 1 training as set out in the Safeguarding Adults and Children's Integrated Annual Report in July 2016, compliance rates for level 1 were between 80% and 96%. For level 2 they were between 60% and 93%, and for level 3, they were between 41% and 69%. They were therefore not meeting targets as stated in the board reports.

- There was comprehensive staff guidance to assist with reporting safeguarding concerns, including flow charts, contact details for internal and external advice and support and tools such as body maps were available for staff to use. Most staff we spoke with were confident about what to do if they had any safeguarding concerns and were able to articulate the referral process when asked.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. Of the records we looked at for medicine, we found that all risk assessments were completed and evaluated. These included assessments for pressure ulcers, nutrition and mobility. There were clear processes in place to deal with deteriorating patients.
- All patient records we looked at showed that people were admitted and continually assessed using the National Early Warning System (NEWS). There had been good results in completion of National Early Warning Score (NEWS) documentation in the emergency department. The management and response to NEWS documentation had been high, being above 90% in the majority of 2016, and up to 96% by year-end.
- An electronic device was used by all staff to automatically identify when observations were needed. Alerts were sent to doctors through the device which ensured that the need for escalation was not missed. However, some doctors said they were inundated constantly with alerts which meant it was more difficult for them to prioritise patients.
- A detailed audit of sepsis management carried out within the emergency department had not provided reassurance that management had improved. Few of the results had improved over similar measures in the April 2015 to March 2016 year. In November 2016, of 18 patients with severe sepsis, only four had all the elements of the sepsis six standard (the collection of the vital signs) completed within an hour, although 92% were eventually completed (although the report does not say when).

Summary of findings

This left 8% of the vital signs not completed, and affected eight of the 18 patients. Seven of the patients had one vital sign not recorded, and one had two missing. Nine patients (50%) had antibiotics administered within an hour, which was a significant deterioration from the audit results for the Royal College of Emergency Medicine. During the last inspection we raised significant concerns around the management of sepsis, but little progress has been made.

- There were safety procedures for staff to follow in the event of overcrowding in the emergency department, but this did not include a rule around constant nursing presence. This meant there were times when staff did not have oversight of patients.
- Due to the high demand on the emergency service, the triage times were not meeting their 15 minute standard, but were showing a noticeable improvement. The triage time, on average, had not reached 15 minutes since at least April 2015. However, since May to October 2016 it had dropped below 30 minutes and was only slightly above this in November 2016 (32 minutes).
- There had been delays with patients presenting with chest pain getting an electrocardiogram (ECG), which had been acknowledged by staff. If patients were not being triaged in 15 minutes due to overcrowding, chest-pain patients should be prioritised, and the nurse in charge made aware of a risk of the ECGs not being carried out in 10 minutes.

Incidents

- Staff were aware of their duty to report incidents and how to action this. Staff were willing to do so, but not all incidents were being reported, and staff told us that action was not always taken when they did report them. Several staff told us that there was little point in reporting incidents as nothing ever happened. This meant that managers were not seeing a true reflection of all potential risks to patient safety.
- There was a high proportion of incidents categorised as 'no harm' when some of these were a 'near miss', or could have resulted in some harm, or where the level of harm to the patient could not have been determined. This meant that not all incidents triggered appropriate investigations or were escalated appropriately. It also meant that the data recording the numbers of harm incidents was not accurate or a true reflection of the situation. We saw several examples of incidents that should have been categorised as serious incidents, but had not been, and some involved patient death.
- Some incident forms that we reviewed contained more than one category of incident, for example a fall and delay in

Summary of findings

treatment, but these were not captured separately due to the way incidents are categorised under one heading, which meant that one or other of those incidents would go unreported for trending purposes. There was no mechanism to ascertain if an incident occurred to an end of life patient unless this was specifically stated in the text, which meant that it was not possible to obtain accurate information for this group of patients to inform improvements in their care.

- There was an immature process for monitoring incident trends and triangulating information. Action plans were not always in place or appropriate and there was insufficient evidence that they had been completed. We saw many examples of poor actions logged against incidents where opportunities for learning were missed, for example, comments like ‘staff will be reminded to take more care’, ‘reiterate to staff member not to do this again’, and ‘remind staff to follow policy’. Some action plans we saw were a list of actions to develop actions. Opportunities for improving services following incidents were frequently missed. Few staff were able to tell us of any changes in practice, or learning as a result of incidents. Staff told us of some improvements they had made at ward level, but this learning was not shared more widely across other wards or departments.
- Senior staff with responsibility for managing incidents told us that the systems and processes in place had not been monitored or audited against policy to provide assurance that they were working. All senior staff we spoke to were aware that improvement was required with the management of incidents, but stated progress had been very slow in this area.
- There was some inconsistency with the quality of serious incident investigation reports and evidence of learning from patient deaths. There was no evidence to show actions identified following serious incidents were reviewed for progress and led to improvements.
- The completion of investigations was not always timely and deadlines were frequently missed. We tracked 15 incidents at random, and of these, six had been open for more than four months. We found 11 incidents from the month of August 2016 where investigations had not been commenced, followed up or completed within expected timescales.

Staffing

- The trust did not have sufficient clinical staff (medical, nursing and other) with the right skills and experience to deliver consistently high quality, patient-centred care as a result of recruitment and retention challenges, inability to delivery new

Summary of findings

staffing models and high agency usage with the potential for sub-optimal care and harm and poor clinical outcomes for patients. This was on the Board Assurance Framework as a specific risk, and there was evidence of ongoing and proactive recruitment drives. There were 53 international recruits at various stages of approval and there had been 15 consultant appointments made since August 2016.

- There were frequent nursing staff shortages across medical wards and the complicated systems to secure agency staff meant that staffing levels in areas fell below safe levels. Neurology did not have sufficient staffing capacity to provide a seven day service.
- There were high registered nurse vacancy rates on the wards. The Cardiac Investigation Unit had a 14% vacancy rate, the Medical Admissions Unit had a 16% vacancy rate, Roskear ward had a 12% vacancy rate and Wheal Prosper ward had an 11% vacancy rate. Phoenix ward had the highest vacancy rate with 23% vacancy.
- The 'safe care' acuity tool which worked on the Association of UK University Hospitals (AUKUH) dependency tool was introduced on all wards. There were twice daily morning meetings to discuss staffing across the trust. This meeting was used to determine if staff should be moved from other areas to meet the hospitals need. Senior staff we spoke with said that staff were moved regularly, leaving wards short, to manage a greater risk in other areas.
- The process to secure agency staff was described as long winded, which compromised patient safety. Staff we spoke with said it could take a whole day to get additional staff as the policy required sign off by the director of nursing. When patients were admitted or patients who had deteriorated who required one to one care to keep them safe, staff needed to leave the bays to sit with the patients. This often left bays without healthcare assistant support. Patients we spoke with felt the impact of this on the quality of care they received. Most patients discussed how the nurses were very busy and that they were sometime too busy to meet their needs.
- For medical staff actual levels did not compare to planned levels. There was a 14% vacancy across the medicine division. However, some areas had higher vacancies. For example, in cardiology out of an establishment of 21 whole time equivalents (WTE) there was a 21% vacancy rate (mostly for consultant grade doctors), equalling five whole time

Summary of findings

equivalents. Also, in the acute emergency speciality medicine service out of an establishment of 45 whole time equivalents there was a 20% vacancy rate (mostly for junior doctors), equalling nine whole time equivalents.

- Medical cover on some wards was stretched with little flexibility to cover during periods of absence. All doctors we spoke with said the workload was heavy and they did not always have enough time to get to the root of things through extended conversations with patients and their families. They were concerned that the interpersonal element of their role was being eroded and current staffing was not sufficient to provide the level of care required.
- The way the cardiologist's rota worked meant that clinics run on the Coronary Investigation Unit where patients could need to progress to a procedure were sometimes cancelled due to no cardiologist being available. Waiting list for elective treatments, such as transoesophageal echocardiogram (a test that uses ultrasound to obtain pictures of the heart valves and study blood flow through the heart), were maintained despite pressures from staff vacancies. However, the trust was working within the two week target for urgent referrals and all patients were seen within seven weeks. This was on the 'worry list' for a number of senior staff, as well as on the risk register.
- There was a waiting list for cardiac procedures within the hospital with some patients not being seen by their 'see by' date. At the time of the inspection there were 1073 new patients and 7160 follow up patients waiting for an outpatient appointment with a cardiologist. Of the patients waiting there were 713 patients waiting beyond their 'see by' date. Of these patients 348 were waiting over three months with two patients waiting for over 10 months. There were 57 patients who had been waiting longer than three months who needed to be seen urgently as a result of increased risk when waiting. We saw an incident form for a patient in cardiology who died as a result of waiting over six months for their urgent treatment. At the time of the inspection all urgent patients were seen within two weeks. We were told that patients were monitored by their GPs for signs of deterioration. Where deterioration had been spotted by the GPs we were told urgent referrals were made.
- The number of consultants in the emergency department and the hours they worked were below recommended levels, although there was active recruitment, and good coverage from junior doctors. The overcrowding in the department meant

Summary of findings

there were times when the nursing staff levels were not adequate. Levels of nursing staff were rising towards planned numbers, but staff raised concerns about cover in the minor injuries' area at night being adequate.

- NHS England (Specialist Level Palliative Care: Information for commissioners, 2016) maintains there should be sufficient medical (and nursing) cover to allow assessment, advice and active patient management seven days a week, and 24 hour telephone advice. There was one whole time equivalent (WTE) specialist end of life consultant. There was also four hours of clinical input from a local hospice consultant but this was restricted to work within the outpatients department. This was not sufficient to provide specialist medical services at all times.
- There was limited cover for the end of life specialist consultant when they were not at work. There was an honorary system in place to cover in the event of sickness, absence or annual leave. The specialist end of life team did not have enough medical or nursing staff to provide a service seven days a week and cover arrangements were limited.

Are services at this trust effective?

We did not rate the trust overall during this inspection.

The team made judgements about three services. Of those, one was judged to be inadequate, one as requiring improvement and one as good.

Summary of key findings for effective:

- The Royal College of Emergency Medicine audits were not given high or satisfactory priority in the year in which they were to be undertaken. The results of the asthma audit were poor although they had used an insufficient dataset, and the audit was done outside of the required period.
- We asked for, but were not provided with up to date audit information for some national audits. The results of these in the previous inspection were worse than the national average.
- There was a lack of ongoing audit information to evidence quality and progress in the delivery of effective end of life services.
- During December 2016 a revised end of life strategy and patient care documents was launched based on national guidance. The strategy lacked accompanying staff training and emphasis to ensure all doctors understood what their roles and responsibilities would be.

Summary of findings

- Whilst new end of life care plans were being rolled out across the trust, there remained a lack of recorded evidence to show end of life care provided was holistic and person centred. There was a reliance on the patient or relatives of the patient initiating and articulating any personalised wishes in order for any actions to be taken. These were not always documented or monitored.
- A continuously funded secondment post for generic hospital staff to work with the specialist end of life team to increase their skills and knowledge was available but not fully utilised.
- There was little evidence of advance end of life care planning being undertaken. Most of the staff we spoke with did not recognise end of life as relevant during the last twelve months of life.
- Discharge was not done in a timely way. All patients were subject to standards set in the SAFER care bundle. Achievement in standards of discharge was significantly lower than the trusts target. Examples of these targets included the timeliness of discharge and discharge on the patient's clinically stable date. This was a worsening picture since our last inspection.
- There was no seven day consultant cover for neurology patients. This increased the risk to patients at weekends. The use of a consultant of the week model had an impact on the effectiveness of treatment. Staff were not supported well and patients were missing important medicines as a result of a lack of accountability under this model. The end of life service did not provide seven day services, and there was limited out of hours cover. All services needed to provide effective care were available seven days a week in the emergency department.
- Appraisal rates in medicine were not meeting targets. Only two wards had appraisal rates higher than the 95% trust target. Some wards were significantly lower with Kerensa ward having 56% compliance and Tintagel ward having 65% compliance. In the emergency department, staff appraisals had improved and were heading towards target.

However:

- There was evidence that people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- In medicine, there was evidence people had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.

Summary of findings

- The link end of life care meetings were a productive forum for learning and sharing clinical and policy updates and were valued by those staff who attended.
- Records maintained by the specialist end of life team showed they were prompt to respond to referrals, although these were increasing and staff were stretched. Staff throughout the hospital told us they understood how to contact the team and highly valued the expertise, guidance and support provided.
- There was a strong ethos in the emergency department for multidisciplinary working and we saw some good examples of this. When people received care from a range of different staff, teams or services, it was coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. There was not robust multidisciplinary working in medicine around discharges however.
- In the emergency department, staff had the right competencies, experience and skills and professional development and competency training had improved. There was an excellent range of training for medical staff, including outstanding simulation training and production of high-quality case studies, teaching materials, guidance and protocols.
- The emergency department had excelled in the timeliness, care and treatment of patients suffering a stroke or trauma.
- There had been improvement in the national stroke audit. The trust had gone from a level E to a level D, which is consistent with the national average.

Detailed findings

Evidence based care and treatment

- The annual national audits from the Royal College of Emergency Medicine (RCEM) were to be undertaken from January 2016 and completed by the end of December 2016. Two were done almost at the end of the 2016 year, and one was done over a three-day period in January 2017.
- There were concerns regarding how medical staff were being provided with sufficient education and information to commit to the new end of life strategy and care plans in practice. The new care plan included many decisions and discussions which were to be led by each patient's consultant. At the time of our inspection care records showed this was not being consistently or fully achieved. Nursing staff also told us they felt some

Summary of findings

medical staff required more education to recognise and consider the appropriateness of treatments when a patient could be approaching end of life. These views were also supported by two consultants we spoke with.

- National guidance (Leadership Alliance, 2014) promotes the early identification of patients who could be potentially approaching the last year of life in order to maximise the effectiveness of care. The majority of staff we spoke with at Royal Cornwall hospital did not recognise this and were focussed on end of life care in the last few weeks or days of life.
- There was a limited audit plan in place to review the effectiveness of end of life clinical practice and the delivery of the service.
- There was a lack of information recorded to identify if end of life patients and those people close to them had been asked about their wishes or requests or if spiritual needs had been discussed. There were concerns as to how staff coming on duty would know what those were, and ensure that patients wishes were followed through.
- Policies, care and treatment pathways, and clinical protocols were based upon recognised guidance, including that of the National Institute of Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM). Quality improvements and clinical standards in the emergency department were based upon guidance from the RCEM.

Patient outcomes

- The results of the RCEM audits were variable. The consultant sign-off audit did not have targets set, but the results showed around a third of high risk patients being missed. There were problems with the sample size in the asthma audit and poor results against delivering or reporting fundamental standards of asthma care. There were areas of sepsis treatment that fell below delivering or reporting fundamental standards, although a high compliance rate (95%) with giving antibiotics within four hours.
- We asked the trust for the most recent data from myocardial ischaemia national audit, and the heart failure audit. However, the trust failed to provide this information within the designated timeframe. The trust has subsequently provided the most current information.
- The trust participated in the National Clinical Audit for Rheumatoid and Inflammatory Arthritis in 2015. However, they did not have a large enough case size to benchmark against other providers. The trust took lessons from this to make improvements for the next submission.

Summary of findings

- The trust had improved the management of patients who were admitted with a suspected stroke. All cases of stroke were audited through the Sentinel Stroke National Audit Programme (SSNAP), to ensure patient safety and to evaluate the impact of the stroke management pathway together with thrombolysis rates. Between June 2015 and July 2016 the overall rating for the trust had improved from a level E (score less than 60% compliance) to a level D (between 61% and 79% compliance, and the national average) for the management of stroke patients.
- However, some indicators for the stroke pathway had worsened. In January 2016 70% of patients were having a CT scan within 60 minutes. However, this had dropped to 67% in December 2016. Another measure is that patients should receive a CT scan within 12 hours of presenting. However, performance had dropped from 95% in January 2016 to 87% in December 2016.
- The trust had not participated in any national or local end of life audit programmes. The specialist end of life team told us they lacked the resources to effectively do this.
- There was a lack of understanding by staff that end of life could and should be considered for a range of life-limiting illnesses and not focused on patients with cancer. This was reflected in the referrals to the specialist end life team.
- There was a high level of compliance in the emergency department with patients being given an assessment for the risk of them developing a venous thromboembolism or VTE (blood clot). In November 2016, 99.4% of patients had been assessed for this risk. This was linked with the electronic prescribing system requiring an entry to confirm a risk assessment for the patient against VTE.
- The emergency department had excelled in stroke patient care. At one point in 2016, the department was delivering the fastest thrombolysis times in England. A review of stroke care had shown that no patient had been missed for thrombolysis or misdiagnosed in the last 12 months.
- There was a strong performance in the indicators for management of trauma patients in the emergency department. In an audit from the Trauma Audit and Research Network for the period July to September 2016 (just published), the emergency department performed in almost all measures above the national average.
- The trust performed well in the national lung cancer audit and either met or exceeded in all key indicators including for data completeness, processes of care, and the treatment or outcome.

Summary of findings

- In the Coronary Care Unit patients may need to have non-invasive surgery to treat emergency coronary heart disease. This intervention is known as a Percutaneous Coronary Intervention. The target for receiving primary percutaneous coronary intervention is within 150 minutes of calling for help. The trusts local target is 75% of patients who are eligible should receive it within that time. Audit results were positive and showed that in December 2016, 8 of the 10 patients achieved the target.
- Lowen ward worked to JACIE (Joint Accreditation Committee- ISCT (International Society for Cellular Therapy) & EBMT (European Society for Blood and Marrow Transplantation) standards when caring for their patients who required stem cells and had regular inspections by the committee with positive results.

Multidisciplinary working

- We saw evidence that staff worked professionally and cooperatively across different disciplines to ensure care was co-ordinated to meet the needs of patients.
- Rotas for junior doctors on different contracted hours did not tie in with timetabling. Doctors working on a 9am to 5pm rota would miss the ward round at 8.30am and relied on colleagues working on an earlier start time to up-date them. This meant that information which should have been shared between doctors may have been missed.
- As part of the SAFER bundle multidisciplinary board rounds had to be started on time and included input from a consultant or registrar, therapists, discharge co-ordinators and ward clerks. Data showed that board rounds were attended by the correct staff almost all of the time meaning that appropriate senior review was happening to reduce unnecessary waiting. However, on Roskear and Wheal Prosper wards over a week's period no consultants or junior doctors attended the board review, as they were on ward rounds.
- A standard of the SAFER bundle was that 30% of patients should be discharged before midday. The trust has not met this standard between April 2016 and November 2016 with an average of 21% of patients being discharged before midday despite consultant ward rounds happening at 8am.
- The specialist end of life team worked effectively across the trust with other departments and specialities for the benefit of patient care. The specialist team went wherever they were required throughout the trust to support staff to provide additional expert end of life patient advice, support and direct patient care.

Summary of findings

- The discharge team worked collaboratively with other community services to support any end of life patients identified as requiring a rapid discharges from the hospital. The team worked with nursing homes and care agencies, district nurses and GPs to organise packages of care and coordinate the discharge of end of life patients. However, please note the comments about confusion around rapid discharge, and system wide working noted under the access and flow section of this report.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The Lead Nurse for Mental Health and Well Being, (who was an accredited best interest assessor) undertook capacity assessments for complex cases or second opinions.
- Staff were aware of all policies regarding consent, mental capacity act and deprivation of liberty safeguards and had access to them through the intranet. Most senior nurses felt competent to raise consent issues and to complete the relevant documentation. They were aware of the policy from initiation to best interest assessment and the revisiting and lifting of deprivation of liberty safeguards where appropriate. A review of consent forms in patient notes showed that most forms had been correctly completed by an appropriate member of the medical team.
- Staff had a good understanding and guidance to follow in relation to mental capacity assessments.
- Consent was documented in accordance with the trusts policy and national guidance for the majority of patient records we reviewed. Staff in the emergency department acted within legal principles when treating patients who were unable to consent due to the nature of their injuries. Patients who arrived unconscious, or not in a fit mental state to provide valid consent (but would otherwise have been able to) were treated in order to save their life or provide essential emergency care.
- Improvements were required to the completion of treatment escalation plans (TEP) by medical staff. These were used to establish what actions were to be taken in the event of patient deterioration. This was based on individual patient circumstances. We looked at 25 TEP records and saw 19 (76%) had been fully completed, three had no reason for not consulting family about decisions, and three were missing the doctors professional grade.

Are services at this trust caring?

We did not rate the trust overall during this inspection.

Summary of findings

The team made judgements about three services. Of those, all three were judged to be good.

Summary of key findings for caring:

- Feedback from patients and those close to them was mostly very positive about the way staff treated people. People were treated with dignity, respect and kindness during their stay.
- People were involved and encouraged to be partners in their care and in making decisions. Staff spend time talking to people, or those close to them and we witnessed staff in the emergency department at a very busy time, taking care to help patients understand what was happening to them.
- Staff had the skills and compassion to communicate effectively to patients during times of distress. This was particularly apparent in the coronary care unit, and in the emergency department.
- Feedback was overwhelmingly positive on Wellington ward. Staff were enthusiastic about the care they were giving. Patients felt that staff went the extra mile and exceeded their expectations.
- Patients and their relatives told us they had been consulted about end of life treatment and care, this was also evidenced in some of the care plans we reviewed, although there was a lack of detailed written information in care records to show what had been discussed with patients and how they had been included and involved in treatment and care.

However:

- Friends and Family response rates were not good across the medicine directorate. For example on Carnkie ward, Tintagel ward and Kerensa ward response rates were below 10%. In the emergency department, although improving the response rate was also very low, but the trust was recommended, in those responses received, by a higher number of people than the England average. For end of life care, there was a lack of survey or other evidence to show patients' needs were being consistently met.
- Due to overcrowding in the emergency department, there were breaches of privacy and dignity for some patients.

Detailed findings

Compassionate care

- There was a compassionate and caring approach to patients. We observed staff being kind, thoughtful and compassionate with patients.

Summary of findings

- Comments about compassionate care were overwhelmingly positive on Wellington Ward. Staff we spoke with were enthusiastic about the care they were giving which had a positive impact on patients wellbeing. Patients we spoke with said “They have restored my faith in the NHS.”, “The staff here should be Ambassadors to other wards.”, and “It’s like living in a Bed and Breakfast, nothing is too much trouble”. Other patients commented about the positive atmosphere and the attitude of staff. One patient said “The care is unbelievable; they don’t let you be sick.” And another said “It’s a nice atmosphere and everyone has a pleasant attitude” And that “We get very good treatment in here”.
- In the emergency department, our expert by experience (a trained member of the public who joined us on this inspection) had the following comments from some of the 13 patients they spoke with:
 - “Since arriving the staff have shown me a lot of respect and dignity.”
 - “I find the staff very understanding.”
 - “The staff could not have done any better. They are brilliant.”
 - “Can’t knock it in here, couldn’t ask for better.”
- We spoke with five end of life patients and four relatives of patients. Visitors told us ward staff were always welcoming and helpful. One relative of a patient said the ward staff were “fantastic, from the domestic staff through to the nurses and doctors, nothing is too much trouble”.
- We observed staff on the wards we visited were friendly and welcoming. Care and support to patients and visitors was provided with kindness and compassion. Staff told us they were proud of the care they provided to patients. However, we were also told by one relative of a patient that they felt personal care, attention and compassion had been compromised due to a lack of available staff. The staff survey showed that all staff were committed to providing high quality care. However, they were not able to provide care as they would like.
- Due to the overcrowding in the emergency department, there were challenges with staff providing privacy and dignity for patients. However, dignity and confidentiality were maintained as far as possible and we saw good examples of this on the wards.
- There was a high level of recommendation from patients completing the NHS Friends and Family Test, although a poor response rate. The percentage of patients who would recommend the service was better than the NHS average, but the response rate was worse than the NHS average.

Summary of findings

- There was no specific end of life Friends and Family audits or other surveys undertaken by the trust to gather patient feedback on care received.

Understanding and involvement of patients and those close to them

- Patients were given opportunities to discuss their cultural/religious beliefs, concerns and preference to inform their individualised care. Patients were involved with their care and the decisions taken. We observed staff explaining things to patients in a way they could understand. Patients were encouraged to be as independent as possible and relatives were encouraged to provide as much care as they felt able to. However, on Kerensa ward one patient said that this was not always the case. One patient said “I need to be out of bed and motivated, but they are so busy”.
- All healthcare professionals involved with the patient’s care introduced themselves and explained their roles and responsibilities. Patients we spoke with, who had capacity, said they felt fully involved in their care whilst in the hospital and understood their discharge plans.
- Patients said they were able to ask questions and raise concerns.
- A survey in mid-year 2016 of trauma patients indicated that most relatives were informed of a patient admitted to the emergency department. From a survey of 29 cases, 27 patients said their relatives were contacted. However, not all relatives were given sufficient information, and this was addressed by the department updating and improving information about trauma cases and transfer.
- There was a lack of documented information in patient’s end of life care plans to show what had been discussed and how patients and those people close to them had been included in discussions and action plans. We looked at 17 care plans and most of these (16) had very limited information.

Emotional support

- We observed staff providing emotional support to patients and relatives during their visit. Patient’s individual concerns were promptly identified and responded to in a positive and reassuring way. One patient said that “nothing was too much trouble for the staff... from the doctors and nurses to the ward clerks.”

Summary of findings

- Patients and their relatives were spoken with in an unhurried manner and staff checked if information was understood. We overheard staff encouraging relatives to call back at any time if they continued to have concerns, however minor they perceived them to be.
- Ward staff told us they supported end of life patients and those people close to them as best they could but were aware it was not always possible to give people sufficient time due to other service demands.
- Emotional support was available through the chaplaincy service (including 12 volunteers) was accessible 24 hours a day, seven days a week. Ward staff told us the chaplaincy service were responsive to patient or relatives requests for visits.
- The cancer resource centre employed one whole time equivalent, (WTE) clinical psychologist and one (WTE) counsellor. These two clinicians were able to provide emotional and therapeutic support sessions to cancer patients or to people close to the patient based on individual need.
- The cancer centre had facilitated different types of emotional support services based on response to patient and carer feedback. For example; benefits advisors were available to speak with every day, monthly 'Look Good Feel Better' pampering sessions were offered by specially trained beauticians. The manager told us future support sessions would be planned directly in response to patient feedback and demand.
- During December 2016 a health and wellbeing workshop at the cancer centre had been facilitated and attended by approximately 80 people.
- There were no follow up processes in place to contact relatives following the death of a family member. Relatives were provided with leaflets on the ward and from the bereavement office which signposted to counselling services in the community.

Are services at this trust responsive?

We did not rate the trust overall during this inspection.

The team made judgements about three services. Of those, one was judged to be requiring improvement and two as inadequate. Therefore the trust was not consistently responsive to patient need in all areas.

Summary of key finding for responsive:

- Although processes were in place to support flow within the hospital there were not enough beds to meet the demand of

Summary of findings

the service. Bed capacity was full and escalation areas (such as theatres and day case surgery) were regularly being used. Additionally there were 40 medical outliers in surgical wards. This took up 16% of the surgical bed base. On the day of the inspection the trust had sought external help and support by the use of escalation (Gold Call) to address the system risk and attempt to reduce bed occupancy.

- Demand on the emergency department and the way it had been required to operate meant too many patients were, at times, waiting on trolleys to be admitted to a ward, and flow was not timely; the department had not met the target to admit, discharge, or transfer 95% of patients within four hours for at least the last two years. At the time of our inspection, this was running at around 77%.
- People were frequently and consistently not able to access services in a timely way due to the over occupancy and the issues with flow. This included delays for an initial assessment, diagnosis or treatment and people experienced unacceptable waits for some services. During the inspection over 100 patients were delayed in hospital due to inability to access community services. Between April 2016 and December 2016 over 1700 bed days were lost as a result of inadequate hospital flow. This was a worsening picture since the last inspection.
- On average 97 patients a month were waiting longer than seven days for discharge. This increased the risks of patients deteriorating, prevented patients who required medical care accessing wards, and caused crowding in the emergency department.
- Senior staff told us that the GOLD calls with system partners were not effective; and the call we witnessed corroborated this on one of the busiest days on record. Some system partners did not attend the call, and others were not prepared with information to provide an overview of capacity in the system.
- Staff in the end of life service told us discharge delays were frequent and resulted from a lack of community resources. There was no information to evidence this. Whilst there were issues regarding the availability of community resources, there were no apparent plans in place to address these issues with community providers in order to make service improvements to meet patients' discharge needs. In some areas there was confusion regarding who had overall responsibility for processing fast track patient discharges through to discharge.
- There was a lack of processes in place to evidence if the end of life care provided was responsive to patient's needs and wishes. Ward staff primarily relied on the patient or relatives to initiate and communicate any requests.

Summary of findings

- There was inconsistent feedback and evidence to show if patients spiritual and cultural needs had been reviewed and any needs addressed, and each patient's personal choice as to where they preferred to receive their end of life care was not routinely monitored and reviewed.
- Complaints in medicine were not being handled in a timely way and in the emergency department, there was insufficient evidence to show complaints led to changes and improvements. A third of complaints in medicine were resolved beyond their timescales, and there was insufficient evidence that learning was shared across the trust.

However:

- The medicine and emergency department services were planned to meet the needs of local people. People using the service could all do so on an equal basis. We found that some reasonable adjustments had been made to manage individual patient vulnerabilities needs. This included patients living with dementia and patients with a learning disability. We found that there had been significant improvements in the stroke service which ensured that the design of services were tailored to meet their needs.
- The emergency department had moved up the national rankings in terms of accident and emergency target waiting times, and the time taken to first treat patients was consistently better than the standard of 60 minutes, with care and treatment appropriately prioritised. People in the emergency department were kept informed about waiting times and alternative access to treatment in the county.
- The cancer resource centre provided a wide range of services, support, training and information based on the needs of patients and people close to patients. The centre also provided training information and information for trust staff and other professionals who provided any services to patients with cancer.
- We found that it was easy for patients to raise a concern or a complaint. There was openness, transparency, and a will to learn from complaints on the wards. We found examples where learning from complaints had resulted in changed practice locally.
- There had been a drive for the complaints team to hold early resolution meetings with complainants, and these had resulted in fewer complaints progressing through to formal complaints.

Detailed findings

Summary of findings

Service planning and delivery to meet the needs of local people

- The premises and facilities were not always appropriate for the number of patients coming to the hospital. The wards did not have the bed capacity for all of the patients requiring medical beds in the hospital. During the inspection the trust had activated the full capacity protocol which meant that bed occupancy was at 100%. The Dr Foster Hospital Guide 2012 identified that occupancy rates above 85% could start to affect the quality of care given to patients.
- The capacity issues of the medicine division were having an impact on the surgical division. Additional areas were opened to accommodate medical patients including Theatre Direct recovery (which had 16 patients in overnight) and Newlyn day case recovery (which had five patients in overnight). One patient in Theatre Direct recovery had been there for seven days. Additionally to this there were 40 medical outliers on surgical wards which had taken 16% of surgical beds. As a result, elective patients had their surgery cancelled which meant they had to wait longer for their procedure.
- The trust had set up an intermediate care and discharge ward where patients who were clinically stable and ready for discharge could be transferred to while they waited for ongoing care. This was meant to be an area for short term stays to free up beds on the wards. However, patients were staying in this area for a long time awaiting discharge due to delayed transfers of care.
- Improvements had been made to the capacity issues in the medical admissions unit. During the last inspection medically expected were being directly sent to the medical admissions unit which led to patients waiting for long periods of time in the corridor. As a result of this several serious incidents had occurred as there was not the right staff mix to safely manage these patients. During this inspection we found that there were not patients waiting outside the medical admissions unit but were being looked after within the emergency department. Please see comments relating to this in the urgent care section of the Royal Cornwall Hospital report.
- The emergency service had been planned in most aspects to meet the needs of local people and those who visited the area. The emergency department had been significantly expanded and predominantly rebuilt to twice its original size in 2013. Senior departmental staff told us the overcrowding in the emergency department was caused, by being unable to transfer people onto a hospital ward, due to a lack of available inpatient

Summary of findings

beds. This was coupled with the use of the department to admit medically expected patients, rather than through the medical assessment unit, which was being used as a short-stay medical ward.

- The low number of beds in the resuscitation area of the department (three for the county of Cornwall) was being addressed by application to the trust board to increase this provision. The inability of this part of the service to perform safely at all times had been investigated by the senior medical and nursing team as part of the business case. An outcome from the request for a step up in provision to five beds was awaited.
- Gender separation was not made possible at all times due to lack of beds.
- Working in partnership with patients to provide end of life services in the location of their choice was part of national strategy (Leadership Alliance, 2014). The trust did not routinely monitor or audit if end of life patients achieved their preferred place of care.

Meeting people's individual needs

- Services were generally planned to take into account the needs of different people. We saw that patients were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs. However, the bereavement service had not undertaken any survey of relatives of deceased patients nor had the trust been included in the national "Voices" survey. In addition, in the 17 end of life care plans we reviewed there was a lack of consistent evidence to show staff or the bereavement service had been responsive to needs. This had also been highlighted as a 'must do' in the 2015 CQC inspection report.
- There were quiet room facilities available in medicine for relatives to use if they were staying with an ill relative or after a relatives death. There was a shower and toilet, drink making facilities and a TV. In the emergency department, the quiet room facilities were basic, and although situated in a less busy area of the department, during times of overcrowding, patients were queued outside this room.
- There was a protocol for responding to patients when the emergency department was overcrowded and patients might be waiting on trolleys in the main corridor. However, we saw that some non-intimate routines, such as taking of blood, observations, or insertion of a cannula into a hand, were being undertaken in the corridor, and no attempt was made to use a portable screen, which was unacceptable.

Summary of findings

- There was inconsistency in the emergency department with patients being given something to eat or drink where appropriate; this was compounded by overcrowding and demands on the service.
- Patients who have a learning disability or who are on the autistic spectrum were supported by the Trust's Learning Disability Liaison Team, which had three full time nurses. This service ensured that patients are given access to an appropriately adapted service which adequately met their needs. A RADAR system was in use at the trust, which was a live system that sent email alerts to the team highlighting any patient in the hospital with a learning disability or autism.
- We saw there were resources and information available to staff on the trusts intranet to support treatment and care provided to patients with learning disability, and for those for whom the English language was not well understood. This included national guidance and easy read patient information and access to an interpreter service.
- Other specialist support at the trust included: a part time adult and children's mental health and well-being nurse; a part time independent mental capacity advocate (IMCA) funded by adult social care; and a part time independent domestic violence advocate (IDVA): funded by an external agency.
- The trust had recently trained 14 hearing loss link workers to provide additional support and advice for patients and staff. They had learned how to carry out basic hearing aid maintenance basic British Sign Language.

Dementia

- There was a full time dementia nurse (admiral nurse) in post, jointly funded by the trust and an external agency.
- Services were planned and delivered around people with complex needs including patients living with dementia. A "This is me" document was available for families or carers to complete to provide information about the person, such as the activities they enjoyed.
- On Wellington ward we saw a memory box and twiddle muffs for use with patients who were living with dementia or had delirium. Twiddle muffs are handmade gloves with items sewn onto them to provide stimulation activity for restless hands commonly associated with patients living with dementia. Patients living with dementia had red trays at mealtimes to indicate to staff that they may need some help and/or support. However, on Kerensa ward that regularly had patients who lived

Summary of findings

with dementia we did not see any memory boxes or planned activities for these patients. Not all staff had attended the trusts one day dementia training course, although a plan was in progress to ensure all staff attended.

- Staff in the emergency department had been trained as part of their mandatory training to understand the needs of people with cognitive impairment. They told us they would endeavour as best as they could, particularly in times of overcrowding, to find a cubicle or somewhere quieter to care for a person who might be anxious or confused.

Access and flow

- Flow through the hospital was severely impacted by delayed transfers of care into community hospitals and into the wider care system. This has been an ongoing issue for the trust, and was exacerbated by a recent increase in temporary closures of community hospital beds and Minor Injury Units. Discussions were continuing with system partners to enable more timely discharges and a system wide plan had been agreed to build capacity to support more timely discharges from hospital and rebalance capacity requirements, however, this had not been delivered and we were told that progress was slow. The trust had also commissioned an external piece of work to look at the discharge processes, and had found that they were overly complicated; work was underway to simplify this, for example initiatives such as discharge to assess, and to implement the recommendations made by the report.
- The number of days where a bed was blocked was recorded by the trust as 'bed days lost'. In Royal Cornwall Hospital the trust had a tolerance of 576 bed days lost per month which was a high threshold. The trust was significantly in breach of their targets with an average lost bed days per month between April 2016 and December 2016 of 1767 days. This was on average 1191 bed days above the target per month. This was a worsening picture since the last inspection.
- On 3 January 2017 there were 176 patients who required transfer into either a community hospital, a care home, or required a package of care in Cornwall (this number included the acute trust and community hospitals in the county). Of these patients, 101 were delayed within the acute hospital.
- Of the 101 patients, 49 were awaiting discharge into a community hospital, 19 were waiting for domiciliary care packages, 16 were waiting for wider community placement and 12 were waiting as their community assessments had not yet

Summary of findings

been completed. On 4 January 2017 there were more patients delayed in the hospital with 113 patients awaiting discharge. Of these patients 43 were waiting for a community bed and 70 for a wider community placement.

- All patients admitted into the hospital were subject to the SAFER care bundle. One standard is that 80% of patients should be discharged by, or on their clinically stable date. However, between April 2016 and November 2016 only 54% of patients were discharged on their clinically stable date putting patients at risk of deterioration and acquiring a hospital-acquired infection, and further compromising capacity.
- Another standard within the SAFER care bundle was that if a patient was in breach of their clinically stable date they should be discharged within seven days. The trust performed well against their internal targets; however, their threshold was high allowing 100 patients to breach the seven day target each month. The average number of patients per month in breach of this standard between July 2016 and November 2016 was 97 patients putting patients at risk of deterioration and acquiring a hospital-acquired infection.
- The trust were in regular contact with outside organisations such as the clinical commissioning groups and the local authority about the pressures around flow of patients and the inability to discharge patients who were medically fit for discharge due to capacity in the local community. However, we were told that support from these organisations was not always forthcoming. For example when GOLD calls were held (with system partners to manage capacity), we were told that other organisations would regularly not attend, so couldn't offer support to the trust with discharges. We observed one GOLD call. Not all expected participants attended the call, and those that did were ill prepared to support the trust with real time information as to capacity in the wider system. The call we witnessed did not result in any wider support or assistance with obtaining beds, and participants had to leave the call to find out further information. Given that this was January, a time of year known for high or extreme demand, more could have been done in the weeks leading up to this period to ensure all system partners worked more closely together to plan for such anticipated situations, and to attend these critical calls in a timely and prepared manner.
- Staff and some system partners we spoke with said that there was a culture of being risk averse to discharge. The trust has recognised this and was planning to conduct a programme of

Summary of findings

work to change this. We were given examples where consultants and therapists had set unrealistic expectations on patient improvements or mobility resulting in them staying in hospital longer.

- The hospital was using the emergency department to admit medically expected patients and some other surgery patients. Patients, estimated by senior staff to be between 25 and 30 a day, tended to arrive often by ambulance towards the end of the afternoon, in the evening or at night, when GPs had undertaken their home visits or out-of-hours doctors were working in the community. At times, this was putting unacceptable pressure on a department not established for this purpose. This significantly added to the failure to meet waiting-time targets, created the privacy and dignity failings for patients, and the increase in delays for releasing ambulance crews.
- Due to demand in the emergency department and elsewhere in the hospital for vacant beds, patients had to wait on ambulance or hospital trolleys. In the department, on the first day of our inspection at around 9am, we found:
 - Twelve patients waiting on trolleys in the corridor for admission to a ward.
 - Nineteen patients in cubicles waiting for admission to a ward.
 - Of the 41 patients in the department, there were therefore 31 (75%) waiting for a bed.
- Due to sustained and intense pressure in the hospital for beds to admit patients, the flow of patients out of the emergency department was not meeting targets. This issue was recognised on the trust risk register and categorised as an extreme risk. On a monthly average measure, the emergency department had not met the target for patients being either admitted, discharged or transferred in less than four hours for A&E in at least the last two years. It had almost achieved the target of 95% of patients being seen in under four hours in a week of November 2016 (94.3% achieved) but this had declined again directly after that and the improved result could not be sustained. In the 17-week period from 14 August to 4 December 2016, the average number of patients being progressed within four hours was 76.9%.
- There were increasing delays in ambulances waiting over 15 and 30 minutes to handover patients.

Summary of findings

- For at least the last two years, there had been almost no patients spending more than 12 hours on a trolley from the decision to admit them to being admitted. The last occurrence of this was May 2015 when four patients waited more than 12 hours.
- In the last 12 months, the emergency department had moved up (improved in) the rankings for four-hour waiting time targets in NHS hospital accident and emergency departments.
- There were effective systems for avoiding admissions to the department. Staff told us the local ambulance trust were effective in identifying which patients needed conveying to the emergency department. Staff also diverted patients to other more appropriate services if they had presented at the emergency department inappropriately.
- There were no dedicated end of life beds at the hospital and the trust did not routinely monitor how many end of life patients assessed as suitable for fast track discharge achieved this and left the hospital within 24 hours. There had been some revision to the fast track discharge processes between wards and the onwards care team. This had resulted in some confusion around who had overall responsibility for completing the process.
- Staff told us that there were frequent delays discharging end of life patients due to a lack of community resources. However, there was no audit evidence to identify the actual cause of delays or to quantify how many end of life patients had been affected. There were no apparent plans in place to address issues with community providers in order to make service improvements to meet patients' discharge needs.

Learning from complaints and concerns

- At the time of the inspection, there was not a dedicated complaints group in place; reviews and sign off of all complaints was completed by the director of nursing. Only the most complex cases were referred to the chief executive. Senior managers told us that whilst improvements had been made, there was more work to do and the complaints process was in transition. We were told a review had been undertaken of the complaints systems and process, and changes had been proposed and were underway; we requested evidence of this but were not provided with any further detail.
- It was acknowledged by the senior managers that the divisions were handling complaints in different ways, which accounted for the confusion we found. For example, the managers we

Summary of findings

spoke to in medicine told us that complaints were managed centrally; however, the central team were clear that ownership of complaints had passed to local teams with divisional oversight.

- Some senior staff told us they did not have access to manage complaints at divisional and departmental levels.
- The complaints policy was in date, but did not describe the accepted processes, as explained to us on inspection. This meant that practice did not follow policy, and staff did not have an up to date reference point when dealing with complaints locally.
- Complaints in medicine were not always being handled in a timely way and in the emergency department, there was insufficient evidence to show complaints led to changes and improvements. A third of complaints in medicine were resolved beyond their timescales, and there was insufficient evidence that learning was shared across the trust.
- There was some evidence of learning from complaints at local level, but limited evidence of wider learning, or of quality improvement being embedded across the organisation.
- There was a relatively straightforward and well publicised system for making complaints to the trust and these would be managed in any format they arrived in. Patients knew how to make a complaint if they needed to and also felt they could raise concerns with the clinical staff they met.
- The central complaints team told us they do not hold a list of trained investigators, and the quality of responses to complainants varied in consistency. The trust did not complete or retain investigation reports related to complaints; responses to the complainant included the findings from any investigation. It was not possible therefore, to obtain any assurance about the quality of complaint investigations.
- There was no complaints training for staff and no programme of training planned for this, despite the planned move from the central team to the divisions.
- There was no process to obtain feedback from, or follow up complainants once they had received their final response.
- Six complaint responses were reviewed by the trust wide team during this inspection and we found the responses to be very corporate, and at times, lacking in compassion and sincerity.
- However, the trust's complaints team had achieved success in reducing the numbers of formal complaints through the use of early resolution meetings.

Are services at this trust well-led?

We did not rate the trust for well-led overall.

Summary of findings

The team made judgements about three services. Of those, two were judged to be inadequate and one as requiring improvement. We also inspected well led at the trust wide provider level, but this was not rated.

Summary of key findings for well-led:

- The trust had in place a clear vision, underpinned by a set of values; although staff mostly understood what the vision and values were, they felt they were not able to fully live by them due to the pressures of the job, compounded by staffing shortages and unrelenting demand on the services. The overarching strategy setting out the vision and values was due to be refreshed.
- Strategic objectives were mostly aligned to the vision and values, however due to ongoing work and involvement with the county's sustainability and transformation plans, the detail underpinning the strategic aims had not yet been formulated or articulated, and staff across all areas we visited were unsure of the impact this would have on their roles and services. Service level strategies were at different stages of development.
- Recommendations from an external governance review undertaken in July 2015 had been accepted, but progress implementing the changes had been limited, and the governance arrangements currently in place were unclear.
- There was confusion around senior leader's accountability portfolios which had yet to be formally agreed, and below board level, the subcommittee and divisional reporting structures were not clear. Some governance committees had been suspended due to operational pressures.
- The processes in place to meet the Fit and Proper Persons Requirements for Directors (FPPR) were not sufficient to meet the requirements of the regulations and did not provide appropriate assurances that adequate checks are being made and recorded to confirm directors were suitably 'fit and proper'.
- Reports to the board did not consistently set out the key issues or risks facing the services, and some areas had not reported as expected, or at all during 2016 due to capacity.
- There was concern about the level of oversight, challenge and scrutiny at board level.
- The risk registers that were in place at the time of the inspection did not accurately reflect the risks to patient safety and the quality of care and treatment. The corporate risk register similarly did not reflect all known risk and appropriate mitigations. There was confusion around the newly reset risk tolerances, which had not been formally documented or disseminated to staff prior to implementation.

Summary of findings

- There was no effective assurance system in place for identifying, capturing and managing risks between ward and divisional level. There was no assurance that risks were being escalated and actioned appropriately. There was a lack of capacity to recognise and respond proactively to emerging risks given the focus on urgent priorities.
- The emergency department risk register had few clinical risks; concentrated on mostly potential environmental risks; and beyond the ongoing situation with crowding, did not address known or current concerns. The end of life service did not have a specific risk register.
- Safety and quality meetings at divisional level were of a variable standard. Whilst all departments indicated the occurrence of meetings, some departments demonstrated a lack of escalation. It was also reported by staff in some divisions that the escalation of issues was futile, with little recognition, feedback or action from executive level meetings.
- There was not a holistic approach to the monitoring of safety and performance data, supported and informed by robust, ongoing clinical audits in all services underpinned by robust action plans to drive improvements. There were a number of areas not being considered through this mechanism, or not demonstrating sufficient priority.
- There was a lack of audit and quality measures to fully evidence quality and risk management issues for end of life patients to maintain and make service improvements. There was no routine engagement with patients or those people close to them to gather feedback in order to make service improvements.
- Quality improvement was not embedded in the culture.
- There was a conflict between delivering high quality patient care, and the time to commit to good governance and risk management.
- Available funds and training available for the development and sustainability of a skilled end of life workforce throughout the trust had not been fully utilised.
- There was an established pattern of increased referrals to the specialist end of life team but there were no plans in place to ensure the team had the capacity to cope with them.
- The issues identified in the core services inspected and the lack of significant and sustained progress since the previous inspection raised questions about the capacity and capability of the trust leadership team. There was widespread anxiety

Summary of findings

about the effect and impact of the sustainability and transformation plan (STP), and the potential dilution of leadership with the chief executive spending more time in her role as lead officer for the STP.

- Leadership of the end of life service was not fully effective and coordinated.
- In medicine, there were low levels of staff satisfaction, high levels of stress and work overload. All staff we met continually strived to deliver the best possible care, but did not feel respected, valued, supported or appreciated. This was particularly apparent on Tintagel ward. More work was needed to improve the continuing poor staff engagement and staff survey results.

However:

- Despite the pressure on the wards there was a culture of openness and transparency within the teams which was cascaded from the ward manager and matrons. All staff we spoke with were positive about the attitudes of the matrons and said that they led the service well.
- Staff were focused to continually improve the care they were giving. This was particularly apparent on Wellington ward where innovate schemes had been introduced to develop skills further.
- The specialist end of life team was held in high regard by staff we spoke with on the wards and other services we visited.
- In the emergency department, there was experienced, committed, caring and strong local leadership. The leaders understood the challenges they faced and had ambitions for improvements and innovation. Staff felt respected and valued. There was encouragement of openness, candour and collaborative working.
- There had been strong innovation and encouragement through professional development and acknowledgement of success and excellence.

Detailed findings

Vision and strategy

- The trust has set out their vision as “Working together to achieve outstanding care and better health outcomes”. This was captured in the strap line “One + all we care”. This was displayed prominently around the trust, on the website and on trust documentation.
- The trust had five values as follows:
 - Care + Compassion

Summary of findings

- Inspiration + Innovation
- Working Together
- Pride + Achievement
- Trust + Respect
- There was a high level operational plan setting out the overarching priorities for the trust for 2017-19. It briefly reiterated the trusts vision and values and challenges the trust was facing. It reflected the changing environment of the NHS and the new working arrangements that were emerging between organisations for delivery of the Sustainability and Transformation Plan.
- The trust had set out four strategic aims as follows:
 - Quality – Provide compassionate, safe, effective care
 - People – Attract, develop and retain excellent staff
 - Partnership – Offer integrated care as close to home as possible
 - Resources – Make the best use of all our resources
- The trust had set the key priorities under each of the four strategic aims, which had been refreshed since our January 2016 inspection:
 - Delivering core standards for emergency and elective care
 - Improving the safety and responsiveness of their services
 - Working with partners to develop and implement the Sustainability and Transformation Plan
 - Adopting a transformation programme to achieve quality and financial goals, consistent with the STP
- The operational plan for 2016/17 included the stated objective for the development of an Accountable Care Organisation (ACO); the aim of this was to provide structure to support integrated services greater than that of existing collaborations/ consortia, and this would be underpinned by a new collaboration agreement with system partners to be put in place in February 2017. The trust had committed to deliver the following under the STP:
 - An updated integrated urgent care pathway within the hospital
 - Working with partners to deliver an infra- structure of urgent care centres
 - Updated and improved paths of care for hip and knee replacement, coronary heart disease and diabetes
 - Integration of the therapies service
 - Working with community partners to improve arrangements for discharge including the Discharge to Assess pathways
 - Adopting new pathways for Frailty and End of Life Care

Summary of findings

- STP plans were not fully developed and senior staff were only able to provide limited detail underpinning the high level aims and objectives.
- Not all staff were fully aware of the hospital's role or involvement with the Sustainability and transformation plan (STP) including the ACO, or how this would affect the various services and their roles within them; anxiety was expressed by many staff who told us they were worried they may lose their jobs. However, we were shown evidence of how the Trust has undertaken a wide-ranging public and internal engagement programme with board members and some senior staff, and other organisations to explain the proposals.
- Of the senior managers we spoke with, although all acknowledged that the STP work was vital and would see improvements across the system, some expressed anxiety about the Chief Executive Officer (CEO) taking on the lead role for the STP at a time when there was still much to do within the hospital, and the impact this would have on internal leadership.
- As we found at the last inspection in January 2016, awareness of the values was variable across different services and staff groups and staff could not consistently describe their service strategy, how it aligned with the corporate strategy or their role in achieving it. Individual service strategies were at different stages of development, for example, the emergency service strategy had clear aims, but there was limited evidence recording overall progress against the 2016/17 priorities. The end of life strategy was in place and had been revised, but not all staff were aware of it, and there was a lack of planning and training to enable and ensure medical staff understood their roles and responsibilities with regards to the strategy. We were told the end of life facilitator would be joining medical rounds to promote the end of life strategy.
- The external review of governance in 2015 had highlighted the need for the trust to refresh its clinical strategy in partnership with clinicians. This had not yet taken place.
- It was not clear where progress in delivering the strategy was monitored or reviewed, or how the trust were delivering key communication messages around the proposed changes.

Governance, risk management and quality measurement

- During the January 2015 CQC inspection, we were told that there had been an external review of governance in July 2015 which had identified some key cross cutting themes and issues, and that the recommendations for restructure and improvement to the governance systems had been accepted

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and approved by the board in September 2015. The board told us they were committed to improving governance arrangements; proposed changes, including new divisional structures and governance and risk frameworks were said to be underway at the time of the last inspection, and smaller clinical divisions were planned for April 2016; this did not happen. A year on from that inspection, the high level divisional changes had only just been approved at the December 2016 board meeting. The new structure presented to us had four divisions overseeing a number of specialities, with each division comprising clinical directors, associate directors, deputy associate directors and divisional nurses, with input from finance, human resources and divisional governance leads. Senior staff told us this model had been in use for some months prior to approval and feedback was that it was working well for some divisions, but not for others. During the last inspection, we were told there had been four main divisions led by clinical directors, which had not been working well, therefore it was unclear what had actually changed under the new proposals. We were told by senior leaders that some of the current delay was due to the need to align the new structures with the sustainability and transformation plans.

- Similarly, at the last inspection in 2015 we were told the board intended to implement a more empowering accountability framework that would devolve more responsibility and control to the clinical divisions, strengthening corporate governance arrangements; during this inspection we were told the same thing, and further that there was inconsistency in the approach between divisions, with overall accountability remaining unclear. Divisional and departmental staff were not always aware of the focus on devolving responsibility, for example, at departmental level, several staff told us that the central teams managed risk, complaints and incidents with input from the various areas. Some senior staff told us that the divisions do not have the required access to the information they need to adequately manage complaints.
- The governance processes to and from these four divisions was also unclear, and was not set out in the current risk management strategy. We asked for information on the sub committees and reporting structures, but the trust could not supply us with any written information on these. Some senior staff told us that this finer detail had not yet been worked out and the priority had been to implement the divisional structures. None of the senior leaders we spoke to were able to clearly articulate or demonstrate governance structures outside of the divisional governance groups in a consistent way. We

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were told further changes were needed, and clarity around senior and executive level portfolios of responsibility and accountability had yet to be finally agreed and confirmed. This correlated with confusion at divisional and departmental level where staff reported a disconnect within the organisation beyond divisional level.

- We were told by senior staff that a number of committees had been suspended due to prioritising urgent operational issues, for example, the committee responsible for human resources and workforce development, the patient safety, experience and effectiveness committee, the senior nursing governance collaborative and the incident overview committee. Senior staff acknowledged there had been some gaps in maintaining governance meetings. In addition, some areas had not been submitting reports, for example, end of life reporting had not taken place throughout 2016 due to capacity.
- Many of the accepted recommendations from the governance review in July 2015 had not yet been implemented, for example, refreshing the clinical strategy, the development of a high priority culture/development strategy to effect culture shift, strengthened assurance to the board around serious incidents and complaints, triangulation of themes and embedding learning across the organisation.
- 'During the last inspection we were told the board was actively reviewing and amending the board assurance and risk framework (BAF); at this inspection we were told that the Board continue to actively review and amend the BAF which is used as a dynamic document to close gaps and strengthen assurance. Each BAF presented to the Board contains track-changed amendments to highlight changes that have been made since the previous meeting. Some senior staff told us the BAF was not aligned to the key issues facing the organisation. The trust board reviewed the BAF on a regular basis.
- Governance around incident management at the trust was insufficient; there was confusion as to ownership of incidents, and it was not clear through which committees incidents were reviewed, reported or escalated; there was little evidence of any scrutiny or challenge at board level, and incident trends were not fully reported, with gaps in the data presented to the board. For example, the summary in the integrated care report that was presented to the board in February 2017, only presented information for December 2016; no information was presented for January 2017. As the board meets typically every two

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months, this meant that the board would not have oversight of key issues for each month. Although there were annual line graphs in this report showing trends, key information for every month was not highlighted or presented.

- We were told there had been an incident management group set up for senior managers to review key issues, but this had not gained momentum and due to other pressures had been stopped. Senior staff informed us incident management had been delegated to the departments with divisional oversight, as in the past there had been an over reliance on the corporate team to manage them; however the managers we spoke with at ward level were not aware of this and believed the corporate team had overall responsibility.
- There was little assurance presented to, or requested by the board in terms of progress with action plans, as there was an assumption these were reviewed, and individuals held to account by the sub committees. We were not assured that this was the case, and we were not confident that all relevant incidents were reaching the subcommittees.
- One output from the informal board meetings was the reset of risk tolerances. Some senior staff told us there remained confusion around this, and that decisions had been made without recourse to the senior leaders in the relevant areas. When we asked some senior leaders to explain how the new risk tolerances worked, they were unable to tell us. The risk management policy had not been updated in a timely manner to reflect these changes, some of which had been implemented before December 2016 when the new risk management policy was approved by the board. Therefore it was unclear to some senior staff we spoke to, how they were to manage or escalate risk.
- We found the risk registers in place at the time of the inspection did not accurately reflect the risks to patient safety and the quality of care and treatment. The corporate risk register similarly did not reflect all known risks and appropriate mitigations.
- There were not sufficient assurance systems which ensured appropriate action had taken place or that the information used to monitor and manage quality and performance was accurate, valid, reliable, timely or relevant. Processes were in place to look at risks categorised as red on a monthly basis and risks categorised as amber every three months by the divisional team. At divisional level the risk register was reviewed through the medical services governance board which met on a monthly basis. Not all risks were being reviewed, for example, there were 313 risks on the medical services risk register. Of

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these risks 151 (48% were overdue a review). Senior staff told inspectors during the inspection “very little” was done to manage risks at a divisional level and the division had narrowed its focus too much. We were told that although risk registers appear on every meeting agenda in the division the time was not being used effectively and “the escalation of risks was not necessarily happening” and the divisional team were not holding sub specialties to account for risks which may be under the radar.

- There were five extreme risks and 37 high risks on the risk register. Several of these risks were associated with cardiology which the register identified were not being mitigated. There were significant backlogs of patients for elective procedures resulting in multiple breaches in referral to treatment times as a result of significant vacancies.
- Management of risks in the emergency department had improved, but there were still some areas not receiving sufficient attention, for example review of completion of serious incident actions. There were a limited number of clinical risks on the register. The only risk we could identify was that relating to the overcrowding in the department (categorised as quality of care risk), which had been on the register since 2011. Other risks the department had been aware of, such as sepsis management, the limitations of the resuscitation area, and risks of receiving medically expected patients, were not recorded. There had been no entries made to the register in 2016 and only one in 2015, which was not a clinical risk. There was contradictory handling of entries rated as extreme risks and elevated to the corporate risk register. The ‘overcrowding’ risk (coded 3411) was scored as 16 on the departmental risk register. However, it was not listed on the December 2016 corporate risk register as would be required for any risk scoring over 15.
- There was no specific end of life risk register and identified risks were held within individual clinical divisions. Records provided by the trust (January 2017) showed there was one end of life risk dated 21 November 2016. This related to a number of identified concerns and inadequate ratings as a result of a previous CQC inspection during January 2016, and did not include other known risks affecting the service.
- There was not a holistic approach to the monitoring of safety and performance data, supported and informed by robust, ongoing clinical audits in all services underpinned by robust action plans to drive improvements. We were therefore not assured staff at every level in the service had a good understanding of all the risks to patient safety or were able to

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assess, mitigate and monitor all known risks. There were key performance and safety dashboards in place, but identified risks were not being escalated or actioned appropriately or discussed at appropriate forums. For example, in November 2016 it was identified that 26% of audits done in September 2016 failed compared to trust targets; recorded actions were only to raise awareness of compliance which was not proportionate to the risks involved. These concerns were not escalated to the matrons meetings or the division's quality assurance meetings.

- There was a lack of audit and quality measures to fully evidence quality and risk management issues for end of life patients and services. For example, there were no routine processes in place to evidence the cause of delays in fast track discharge for end of life patients. There was no process in place to benchmark and evaluate how patients were potentially being identified as approaching the last year of life and what subsequent actions had been taken.

Leadership of the trust

- At the time of the inspection and over the last few years, there had been a significant and ongoing period of instability at board level. Since the first inspection in January 2014 there had been three chief executives in post, two of those on an interim basis. A permanent chief executive officer (CEO) was appointed in April 2016. A new chair was appointed in 2015 and had since stepped down in August 2016, with an interim chair covering whilst awaiting the start date for the newly appointed chair whose position had recently been confirmed.
- The director of nursing was an interim post at the time of the inspection, having been in post since December 2015, and this post was due to end in April 2017, with plans for recruitment to a permanent post underway. An interim medical director was in post since October 2016 for a period of 6-9 months and this post has been advertised externally. Similarly, the chief operating officer post was interim from October 2016, with this post also being advertised externally. The newly appointed director of human resources commenced in post in December 2016, and the director of corporate affairs commenced in post in January 2017. The director of finance was the longest standing executive member of the team having been in post for six years.
- The message we received from executive and non-executive leaders was a sense of change for the better with the appointment of the current CEO and the energy and drive she brought to the role, in conjunction with the STP plans and

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progression of integrated care across the system. This was somewhat tainted however, by concerns about who would take the steer internally as it was recognised that much of her time would necessarily be consumed with outward facing issues (as the county STP lead). Whilst it was acknowledged by all that this work would be crucial to solving or easing some of the trust's internal and system wide pressures, the need for strong, clear and focused internal leadership was reiterated by many senior staff we spoke with. This was particularly the case in terms of providing some much needed stability and consistency at board level, and through that stability, 'getting our own house in order', which was a phrase we heard from several leaders at various levels.

- Key stakeholders expressed the view that, for a long time, the trust was inward looking and had only relatively recently fully engaged with relevant partners and peers outside the trust to develop appropriate initiatives to drive improvements. The appointment of the current CEO in April 2016 was seen as instrumental in this change, although it was acknowledged that there is still a long way to go. There was a sense communicated to us by many senior staff, and indeed by system partners, that although relationships across the patch were improving, there was much historical 'water under the bridge' that was still lurking below the surface of communications and potentially blocking the development of progressive and effective relationships.
- Concerns were expressed by a number of senior leaders about the lack of challenge and scrutiny by the board. We were told assumptions were made about the quality of oversight and challenge at the subcommittees, and that often, board papers were accepted at face value, for example the quality strategy presented in December 2016. Of the board papers we reviewed, a number of them set out high level findings as expected, however, key headlines that may provoke debate and challenge were not always highlighted with sufficient priority. An example of this would be the unacceptably high rates of incidents involving violence and aggression to staff clustered mainly, though not exclusively in one area over a six month period. Other examples included compliance with safeguarding training and oversight and scrutiny of risks discussed elsewhere in this, and the main hospital report. Senior leaders told us that there was often insufficient time to scrutinise board papers, and since the board meetings were every other month, some key

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issues may be overlooked. In addition, due to time constraints and the nature of the subcommittee structures and methods of working, not all members of the board had oversight or input on quality and safety issues overall affecting the trust.

- Every other month, the trust held informal board meetings for development and to provide focus on key issues. Sessions were facilitated by the trust chair, and where appropriate, the subjects being discussed were introduced by the relevant accountable officers. The sessions have mainly focused on STP developments, as well as the development of trust plans for 2017/19, ensuring all board members are well briefed on issues before decisions are taken at the board. There are no formal records of the meetings, but we were told any actions arising were captured for taking forward. We were not provided with any evidence as to how or where these actions were monitored.
- Divisional leaders told us they did not have the capacity or capability to lead effectively; they spent “their entire time firefighting” and didn’t have sufficient time to improve services. Work which should be a priority (such as work on the integration of services for counties sustainability and transformation plan) was not happening as they needed to rectify significant issues within hospital. One senior manager said “we can’t get to an integrated point until our own house is in order”.
- There was a demonstrable disconnect between the wards and the divisional management team. We were told that concerns were not being heard above matron level. One member of staff said that “concerns are escalated into oblivion”. We were given examples where multiple incident forms had been filled in due to staffing levels but no actions were taken as a result. One member of staff said that the divisional team reacted to concerns rather than acted proactively and that “the only time things change is when CQC come in”.
- The high turnover of staff within the executive team had an impact in the medical directorate. The high turnover had caused delays to work streams and raised uneasiness amongst staff. For example, the strategy to manage patient flow through the hospital was regularly changed as new chief operating officers came into position. Staff on wards were prepared for change and would continue to drive for high-quality care. However, staff said the continued changes at senior management level created a lack of stability and concern about a lack of commitment to the trust. Some senior staff told us “it’s become the norm for people to leave we just expect it now.”
- The pace at which improvements were made, particularly around the management of hospital flow was inadequate and

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senior staff we spoke with felt they were not supported by the wider system. Almost universally in the medicine directorate senior staff had the view that the wider system could do more. One member of staff said “the system doesn’t feel the risk or the pressure” and that their actions are not proportionate to the urgency or risk involved. Another member of staff said the trust was “coordinating the whole system” and that they were having to put pressure on external organisations to lead effectively. One example we were given was when the trust had conducted bed modelling exercises which showed that over the winter period of 2016/ 2017 the hospital would need an additional 80 beds to meet demand. However, the trust did not get a response from the local clinical commissioning group as to how this could be addressed. One member of staff said that there was an “expectation to muddle through”. Another example was when the trust commissioned an external report on discharge in the county, the report made a list of recommendations which were not acted upon by the wider system. The board assurance framework also detailed system actions which were noted to have not been delivered against their target dates.

- We were told that senior leaders were not visible on the wards. Many staff we spoke with could not identify who the senior team were and those who did know them said they did not have the confidence to approach them. An example of this was one member of staff said “I would not know who the executive team were if I passed them in the corridor”. However, staff we spoke with were positive about the matrons and their ward level leaders.
- The nursing leadership of the wards had the skills, knowledge and integrity to lead the service. They were an experienced and strong team with a commitment to the patients, and also to their staff and each other. They were visible and available to staff and we received positive feedback from staff who had a high regard and respect for their managers. There was a strong senior nursing team and all staff we spoke with felt supported by their matrons. They in turn were proud of their teams and recognised that staff worked hard within their roles. One manager told us they were most proud of the “safe, high quality care given” and staff who “always did the right thing for the patient.” One nurse we spoke with said that there was good leadership in the wards and that the matrons “create a buffer to the inconsistencies in the executive team”.
- There was experienced, committed and dedicated leadership in the emergency department. The team was led by an experienced consultant in emergency medicine appointed in

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April 2016. They were supported by a team of knowledgeable and skilled consultants and doctors. The nursing staff were led by two experienced matrons who worked complementing shifts. They were supported by staffing teams led by experienced sisters or charge nurses.

- The leadership team had the capability and experience to lead the department effectively, although capacity was affected by pressure on the service and an under-staffed consultant workforce. The department was able to deliver effective emergency care to keep people safe and meet their needs, but there was pressure for time to learn, audit, improve and excel.
- The leaders, both within medical and nursing staff, clearly understood the challenges to delivering good quality care. They could identify areas where the department needed to improve and what it would take to address these. Since our previous inspection, the local leaders had implemented actions and strategies to resolve some areas of poor service delivery. This was done through various processes, including valid auditing of systems and care delivery; changes to care plans and pathways to address gaps and risks; piloting new approaches to patient flow, and recognising when these had not worked as hoped.
- Leaders within the emergency department were visible and approachable. The leaders were treated with respect by their staff, and seen working in and among their staff at all times providing guidance and advice. They took time and space to lead effectively, and step back at times from the detail, but we observed they always had time for staff concerns and questions.
- There was clear clinical leadership from the specialist end of life consultant and specialist nurses in respect of meeting the clinical needs of patients and in supporting generic staff. The specialist team were held in high regard by staff we spoke with on the wards and other services we visited.
- The specialist consultant had recently resigned from the trust lead role. The replacement person was invited to take the role and did not have any specialist end of life training, skills or experience. The executive trust lead for end of life care told us they were confident the newly appointed trust lead would be able to deliver the actions related to the end of life strategy. There was no non-executive director for end of life care.
- Improvements were required in order for all staff to fully ensure all end of life practice and the roll out of the new strategy was coordinated and consistent trust wide. There was however, perceptible tension outside of clinical decision making, between senior end of life staff which could have impacted on the effectiveness and provision of the service.

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Culture within the trust

- The external review of governance in 2015, described in more detail above, highlighted that further work was needed to develop a positive, enabling and empowering culture within and across the workforce. Action plans had been put in place with board support to address these concerns. The 2015 staff survey (latest data available) had not demonstrated significant improvements (see staff engagement below) although the situation had not worsened during the year.
- There is an interim freedom to speak up guardian at the trust, and the post was being advertised at the time of our inspection; this role would be for two days per week and would link in with the non-executive lead for whistleblowing.
- The trust had remained in the bottom 20% of acute trusts for harassment, bullying or abuse (HBA) from their own staff (32% against a national average of 26%). Staff in the medicine division told us they did not feel respected or valued which had a negative impact on their wellbeing. The senior nursing team felt that often their professional judgement was questioned by divisional staff. An example of this was the lengthy processes required when making a request to request additional shifts. Some staff we spoke with said that supportive services such as human resources, governance, learning and development and infection control did not always provide the support required and clinical staff said they had to “sort it out themselves.” We spoke with one senior nurse who said “they can’t bear to see junior nurses crying anymore” and that “they had never worked anywhere as uncaring as this”.
- Due to lack of support from the divisional team, morale and wellbeing on Tintagel ward had declined. The ward had changed in April 2016 from an elderly care ward to a joint elderly care and neurological ward but staff felt that they were not supported through this transition. The senior team told staff that they would be getting additional training to manage the complex neurological patients, but this had never happened. We were told that any support that was needed they had to find themselves.
- Workload was high and relentless and although the teams felt they worked well together they were concerned the pace was not sustainable. The culture at ward level encouraged candour, openness and honesty. Most staff we met said they felt supported within their teams to challenge and raise concerns and anxieties. They were confident they would be heard. However, this was only at a local level. One member of staff described the workload like an elastic band being stretched that was about to snap.

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- Staff in the emergency department in contrast, told us they did feel valued and respected, and there was support and cooperation between the emergency department and the executive team. The clinical director and other senior staff met regularly with the chief executive and the director of nursing. When the emergency department was in a period of escalation (overcrowding or similar pressures) this was rapidly escalated to the site coordinator and the executive team. We heard from staff on all levels in the emergency department about commitment to their teams, their managers, the hospital and each other. However, the reception staff sometimes felt they were not included in consultations or outcomes of matters that would or could affect their roles. They often found out about changes by word of mouth and not formally.
- All the staff we asked in the emergency department said they would be willing to raise any serious concerns to the leadership team, and they were confident they would be heard. In medicine, staff told us they would be heard by their local managers, but not beyond this. Results from the 2015 staff survey showed 92% of staff were aware of the trust's Raising Concerns Policy, and knew how to go about reporting concerns, however, only 58% said they would feel secure raising concerns, and only 40% were confident that action would be taken; this meant the trust scored in the lowest 20% when compared with the national average. In addition, only 27% of staff agreed that communication between senior management and staff was effective; only 26% said senior management involved them in important decisions; and only 23% said that senior management acted on staff feedback. This was worse than the national average.
- Scores on stress had improved since last year, and were now average when compared to the rest of the sector. For example, 55% of staff reported attending work when feeling unwell (a significant improvement from 62% last year); 32% reported feeling pressure from their manager to attend work when they were not well enough and 25% reported feeling similar pressure from colleagues.
- The specialist end of life team was committed to providing high quality treatment and care for patients at all times. This was evident in how patients were spoken with and about, and how general hospital staff praised the service the specialist team provided.
- The specialist team were focused on partnership working with colleagues. There was an emphasis on 'doing with' rather than 'doing for' in order to promote education, increased skill and confidence.

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- Most of the end of life staff we spoke with told us they enjoyed working for the trust and that they felt supported by the colleagues and teams they worked within.

Equalities and Diversity – including Workforce Race Equality Standard

- As part of the new Workforce Race Equality Standard (WRES) programme we have added a review of the trusts approach to equality and diversity to our well led methodology. As part of this inspection we looked at what the trust was doing to embed the WRES and race equality into the organisation as well as its work to include other staff and patient groups with protected characteristics. The equality & diversity function was overseen by the Associate Director of Workforce.
- Under the Specific Equality Duty requirements of the Equality Act 2010, all Public Sector organisations are required to publish equality data on an annual basis to prove compliance with the Public Sector Equality Duty. The trust submitted its annual equality report to the trust board in April 2016. This report highlighted the performance of the trust in relation to race equality and actions required to support further development.
- The trust's 2016 WRES report showed there was 86.5% white British and 3.9% white other representation in the overall workforce. There were 6.4% of staff whose ethnic origin was not disclosed. The defined black, minority and ethnic (BME) representation in the overall workforce was therefore 3.16%, which was higher than the percentage of BME people living in Cornwall (1.8%, 2011 Census).
- There was a higher ratio of BME staff in non-clinical roles band 6 and band 8a but an absence of BME workers in all higher bands. The data shows that white staff were more than twice as likely to be shortlisted for positions than BME staff (23.26% and 12.5% respectively) and that whilst 83% of white staff believed the trust provided equal opportunities for career progression or promotion, only 69% of BME staff answered this question positively. The trust had identified actions to address this, for example, the initiation of a buddy and coaching scheme.
- There was no evidence that BME staff were more likely to enter a formal disciplinary process and no evidence of any significant difference between white and BME staff accessing non mandatory training. BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months was 32%, and 28% for white staff; whilst the BME percentage had reduced from 40% in the previous year, it was still 4% higher than the national average. BME staff experiencing harassment, bullying or abuse from staff in last 12

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months was 28%, which had reduced from 45% in the previous year, and was lower than the percentage of white staff (32%). A zero tolerance campaign had been introduced in all divisions to address this.

- The trust had identified an issue with staff not entering their ethnic, religious or other sensitive information onto the employee self-service system which meant there were gaps in the data capture, for example, doctors and midwives had the highest number of 'unknown' fields ticked against equality and diversity declarations. A campaign to raise awareness of the need to do this had been launched, but there were concerns this may not go far enough to ensure that this information is captured and acted upon in a timely manner.
- Equality and diversity data relating to the volunteer workforce has only recently been requested and needed improvement as only three people had recorded all their equality data.
- Every policy and service at the trust had an Equality Impact Assessment completed to assess for any negative impact against the nine protected characteristics.
- The trust had applied to the Employers Network for Equality & Inclusion to examine progress on being inclusive and supportive employers, and had been awarded silver.

Fit and Proper Persons

- The processes in place to meet the Fit and Proper Persons Requirements for Directors (FPPR) were not sufficient to meet the requirements of the regulations and did not provide appropriate assurances that adequate checks are being made and recorded to confirm directors are suitably 'fit and proper'.
- During the last inspection we were shown a Fit and Proper Persons (FPP): Director's Policy and were told this was in place, dated 1 April 2015. This was a comprehensive policy covering arrangements for both recruitment and ongoing assurance. The policy included the detail of procedures to be followed including proforma declarations and checklists. When we went back to the trust on 2 March 2017, the trust were unable to locate this policy, and were not aware of its existence. We spoke with two executive directors, both relatively new in post, who were not able to locate this policy during the four hours we were on site, or subsequently. We were told that they were in the process of drafting version 1 of a new FPP policy. Other policies we were shown, for example the recruitment policy which was under review, did not sufficiently cover FPP arrangements. Therefore we were not assured that there was an effective or documented process in place to cover FPP arrangements either upon recruitment or an ongoing basis.

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- We asked to review all executive and non-executive personal files containing FPP information; we were provided with 13 files, and we were told that two were locked away and they were unable to access them at the time we were on site.
- Of the 13 files we saw, seven were executive directors, and six were non-executive directors (NED).
- In the non-executive directors files, we found two examples of NED's who had started work prior to confirmation of a clear DBS check; one for three months, and another for one month.
- In one NED file and one director file, we found an email from human resources administration team stating that confirmation of satisfactory DBS checks had been received, but we were unable to ascertain whether these were enhanced or standard DBS checks, the certificate numbers or the date that they had been obtained.
- In two NED files, we found items that should have been explored further, but found no evidence that further due diligence had been carried out. We found evidence in one director file that required further exploration, but no evidence that this had been done. One NED file did not contain a check of the disqualified directors register.
- There were three examples where CV's identified gaps in employment history that had not been explained.
- We did not see any professional registration checks in any of the relevant files we reviewed. The trust told us they did not hold any information on qualifications for NED's, as these, along with references, were held by NHS Improvement, and they were entitled to take assurance from this. For directors, only three files had any evidence of qualification checks.
- All files except one director file contained FPP declarations; however, some of these had not been refreshed for some time. Not all appraisal information was present in the files. Those appraisals we did review, had been signed by the member of staff, but not signed off by the person conducting the appraisal. The trust has subsequently informed us that all appraisals have been conducted.
- The trust had moved to using a recruitment agency for the newly appointed directors, and were provided with a 'due diligence' pack; these packs included information gleaned by the recruitment agency by way of references. However, most of these were telephone references, and appeared to be a summarised interpretation of what had been said. This meant that there were no signed and dated references directly from those individuals who had provided the reference.
- We found two director files without any references at all, and one director file with one verbal reference only.

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- One file did not contain any identity checks, and we only found three files where right to work checks had been undertaken, or documented.

Public engagement

- The trust engaged with patients and the public in a variety of different ways, including local and national patient surveys, the NHS Friends and Family Test (FFT), and contacts via the trust's Patient Advice and Liaison Service (PALS). Patients were encouraged to be involved and had attended trust board meetings. Patients had attended board meetings to present their patient stories.
- The FFT is a single question survey which asks patients whether they would recommend the service they have received to friends and family. In the 2015/16 reporting year, the trust received approximately 70,000 responses of which 83% were positive reflections of care and treatment.
- Staff engaged with patients and their relatives to gain feedback about their experiences and the quality of services. Some areas we visited did this very well. In other areas, staff did not feel there was sufficient time to specifically gather feedback. There were examples where feedback was used to improve practice and enhance the patient experience at local levels. Nursing quality dashboards enabled wards to look at their individual patient experience data per ward, which enabled patient experience to be viewed directly at service level. FFT response rates in some areas were very low and below the national average. A new system had been implemented and work was in progress to monitor its success with increasing response rates across the trust.
- There had been limited engagement with the public, patients or relatives to gain local or national feedback about the end of life service. No surveys had been undertaken for during the past year to ensure that the service provided met patients and their relative's needs. The chaplaincy service told us they collated patient stories to share understanding and feedback with staff but no information was provided following our request, to evidence this.
- There was also no formal or informal follow up contact with bereaved relatives to discuss how care was or should be provided. However, the bereavement office was providing comment cards for relatives to complete if they chose to but these had not been evaluated.
- As part of a continued effort to improve public information, the trust redesigned and relaunched the public website. It was user

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friendly and easy to navigate and set out information clearly. In addition, the trust had added a section providing real-time information on access to urgent and emergency care and minor injury units throughout Cornwall and Isles of Scilly.

- The emergency department was the first in the Cornwall peninsula to gain regular structured feedback from trauma patients. The survey undertaken in June 2016 with 29 patients led to improvements in the information sheets given to patients and relatives being transferred to another hospital.
- The emergency department had produced a short video about why it was “great to live and work in Cornwall”. This had been uploaded to the internet, and leaflets produced to give away with contact details. This had led to other departments wanting to produce their own videos and promotional materials. There had been 3,807 views of the 5-minute video by 20 January 2017.
- There was a commitment from leaders at the trust to conduct and take account of public consultations with regards to any proposals for changes to the way care and services are delivered as part of the sustainability and transformation plan (STP), and this was reflected in discussions recorded at board level.

Staff engagement

- Staff engagement had been on the corporate risk register since August 2010, and the trust had a long history of poor staff survey results, consistently finding itself in the bottom 20% of acute trusts across many key areas surveyed.
- The 2015 staff survey (the latest data available at the time of the inspection) had a staff response rate of 38%, which is below the national average of 41%, and lower than the response rate from the previous year (45%). Compared with the previous year's results and of the 90 questions asked, the trust had seen 12 positively statistically significant changes, no negatively statistically significant changes, and 10 key findings remained the same.
- The feedback from the 2015 Staff Survey told us that 50% of staff said that they looked forward to going to work (compared to 41% the previous year); 68% staff were enthusiastic about their job (compared to 60% the previous year); and 45% were satisfied with the recognition they received for good work (compared to 39% the previous year). Although slight improvements were noted, all of these questions were still in the bottom 20% when compared to other trusts.
- Other questions where the Trust performed poorly compared to its peers (in the bottom 20%) include: staff agreeing that they were able to do their job to a standard they were personally

Summary of findings

pleased with (69%, compared to a national average of 80%); staff satisfied with the extent to which the organisation valued their work (29% compared to 40%); staff agreeing that they were able to deliver the patient care they aspire to (54% compared to 66%). The trust scored at the bottom of the sector on whether staff thought patient / service user care was the organisation's top priority (55% compared to 73%), and whether the organisation acted on concerns raised by patients / service users (55% compared to 71%).

- The 2015 staff opinion survey action plan was presented to the board in April 2016, and set out four key priorities for improvement: improving staff engagement using Listening into Action as the key enabler; giving staff freedom to speak up; improving staff health and wellbeing, with a particular focus on stress; identifying areas where there are spikes in bullying, harassment or abuse from colleagues or service users. There was evidence that these work streams are ongoing, and there was acknowledgement of, and a stated commitment to making sustainable change to staff engagement from the executive leaders that we spoke with.
- During 2015/16 for example, the trust held a series of Chief Executive 'big conversations' as part of the Listening into Action programme. Over 300 staff attended each series of conversations. A number of smaller projects were developed out of these conversations, and were led by clinicians, with local teams encouraged to take up the Listening into Action approach in their own areas; this led to projects such as the creation of the cardiology radial lounge to improve patient experience.
- In order to track the impact of the Listening into Action programme, the 'Pulse Check' survey was developed. This was a quick, simple 15 question survey based on core questions from the national NHS staff survey to measure staff engagement. Pulse check surveys were completed in July 2015 (2148 responses), January 2016 (1546 responses) and September 2016 (1544 responses) to measure progress following Listening into Action activity. The results show a slightly improving picture, however, the scores remain very low for all 15 staff engagement questions. For example, the highest score showed that 58% of staff 'understand how my role contributes to the wider organisational vision' - up 8% from July 2015. One of the biggest increases was on the question 'our organisational culture encourages me to contribute to changes that affect my team/department/service' - up by 12% but still

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only to 38%. The current lowest score is 23% of staff believe 'day to day issues and frustrations that get in our way are quickly identified and resolved' – up 10% from July 2015 but still a very low score.

- The Chief Executive (CEO) had in place a range of short video conversations accessible to staff through YouTube, aimed at changing the way staff hear messages directly from senior leaders. Staff were encouraged to submit questions which would be scheduled in to future conversations with the CEO.
- The trust communicated with staff through a Team Talk newsletter, and a daily bulletin; however there was a lack of assurance that these communication methods reached all staff.
- Individual staff and teams were recognised for their outstanding achievements and contribution to care and services at the trust's One + all | We Care Awards. In November 2016, 150 individuals/teams were nominated for this award and 21 were successful.
- All the staff we met as part of our inspection were committed and motivated to delivering high quality and compassionate care. However, as reflected in the staff survey and pulse check survey, most of the 50 staff we encountered at the drop in focus sessions told us they did not always feel they had a voice or were empowered to make sustainable changes.

Innovation, improvement and sustainability

- Leaders in medicine had introduced innovative ways to strive for continuous learning, improvement and innovation. For example 'MASH up Monday' training had been introduced on Wellington ward which involved weekly training sessions on a variety of subjects. A ward sister involved in this won a trust pride and achievement award in November 2016. Another example of this was a respiratory doctor organising a training day at the local pub for training, discussions and lunch around respiratory care. This was well received by staff and the matron we spoke with said the doctor was enthusiastic and engaging.
- Staff were focused on continually improving the quality of care for their patients. Staff we spoke with showed a willingness among teams to develop services and the felt encouraged to share ideas. One example was where the clinical matron for the cardio-respiratory team was nominated for a Nursing Times award in January 2016 for introducing 'matrons rounds' to promote good quality care and treatment.
- The emergency department was innovative and staff were keen to make improvements and celebrate in their success. The Blood Transfusion Team had won a national award in February 2016 (NHS England's Innovation Challenge Prize) for developing

Summary of findings

a secure labelling system for blood samples. This had been introduced and successfully implemented in the emergency department and had demonstrated a significant drop in rejected samples. This had also meant a reduction in blood taken from patients as samples were managed correctly the first time.

- There were other innovations and improvements. These had included:
 - The transfusion team attending all code red trauma calls. The transfusion coordinator remained with the patient throughout their treatment to ensure the correct use and type of all blood and blood products.
 - Medical staff were now able to book a scan for a patient with a head injury without referring first to a radiologist (providing the criteria met National Institute for Health and Care Excellence or NICE guidance).
 - A deep-vein thrombosis (blood clot) protocol had been improved to ensure prophylaxis (preventative treatment) was given for all lower limb fractures.
 - There had been improvements to the clinical pathway and tests given to patients presenting with potential heart attacks (acute myocardial infarction). A certain specific test (high sensitivity troponin assays) was now undertaken earlier to diagnose and treat patients with acute myocardial infarction.
- Improvements in the provision and sustainability of a skilled end of life workforce throughout the trust had not been fully utilised. McMillan continuously funded a three month secondment post for generic staff to work with the specialist end of life team. This was provided to increase skills, experience and knowledge. Each secondee completed a project relevant to their clinical area and took on the end of life link role for their service. This post had not been given priority throughout the trust. The last secondee had been during March to May of 2016 and previous to this the secondment post had been suspended for more than a year.
- We looked at records which showed the rate of referral to the specialist end of life team had been steadily increasing whilst the size of the team had remained static. From April 2013 to March 2014 the number of end of life patients referred was 713, between April 2014 and March 2015, the number was 830. Between April 2016 and November 2016 the number of end life patients referred was 599, and was projected to be 958 by the end of March 2017.
- There was no succession planning in place, or formal cover arrangement for any long term absences for any of the

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specialist end of life team. However, the trusts executive lead for end of life care told us they were in discussions with a local hospice to develop a more shared approach between the hospital and community services for the delivery of end of life care.

Overview of ratings

Our ratings for Royal Cornwall Hospital

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

Our ratings for Royal Cornwall Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Outstanding practice and areas for improvement

Outstanding practice

- There was an outstanding commitment to medical simulation training in the emergency department and this extended to the production of detailed and valuable case studies. This provided education for staff, but also awareness of human factors in a busy environment, and how staff might react to those.
- There had been an outstanding response to trauma and stroke patients in the emergency department. The department was among the top hospitals in the country for providing timely and appropriate care.
- There was an outstanding commitment to mandatory training for the nursing staff in the emergency department with three-day sessions held to cover this and other key topics for continuous professional development.
- Despite unprecedented overcrowding, the emergency department was calm and professional during our unannounced inspection.
- MASH up Monday training on Wellington ward – small training sessions on the ward done by the ward sister and other relevant staff. Now extended to something each weekday. Ward sister won a trust pride and achievement award in November 2016 for this.
- Clinical Matron for the cardio-respiratory directorate was nominated for a Nursing Times award for ‘Matrons Rounds’ – promoting safe, effective, caring, responsive and well led care, January 2016.
- One of the respiratory doctors had organised a respiratory day, for staff, at an external venue that included training, lunch and discussion about respiratory care. The matron said the doctor was very enthusiastic and staff were looking forward to the day.
- The use of an electronic pharmacy system to ensure detailed exchanges of communication to community GP’s and pharmacists. This ensured that the community teams were up to date in dose changes, new medicines, discontinued medicines, and those that were to continue but were temporarily stopped.

Areas for improvement

Action the trust MUST take to improve

- Review, document and implement the governance processes, subcommittee structures and reporting lines to and from the board and ensure staff this is communicated to staff.
- Review the governance in the emergency department and across medicine to ensure it has evidence that recognises and addresses risks, safety, and quality of care. This needs to include actions from avoidable patient harm, progress with audits, and demonstrable learning and improvements when there are incidents, complaints, and other indications of emerging or existing risks.
- Review and improve governance processes to fully evidence all quality and risk management issues for end of life patients, and ensure these are reported in line with the risk management policy and processes.
- Review and implement a robust policy and associated processes for executive and non-executive directors in terms of fit and proper person’s checks, both upon recruitment and on an ongoing basis.
- Review and implement the systems and processes for managing corporate, divisional and local risk registers and ensure that all staff are clear about their roles and responsibilities. The risk register must be improved to recognise all risks, particularly clinical risks, and consider where there are gaps in what is reported and how they are reviewed.
- Review the incident reporting systems and processes and provide assurance this is a fair reflection of the risks in the trust at all times. Ensure any categorisation of an incident is accurate in order to ensure learning and appropriate escalation from all incidents, including ‘near miss’ events. In addition, to ensure that duty of candour is correctly applied in all cases.
- Review how end of life patient care is captured within the trusts incident reporting system to ensure

Outstanding practice and areas for improvement

incidents reported in all categories can adequately identify if they also involve end of life patients, and improve and educate staff trust wide to recognise what end of life issues could or should be reported as an incident.

- Present incident information with more prominence in safety reviews and governance committees with a responsibility for risk, and embed and demonstrate learning and improvement.
- Address timeliness and inconsistencies in the quality of investigation reports for all serious incidents.
- Demonstrate learning across the trust from patient deaths, particularly, but not limited to, any that were unexpected or avoidable.
- Ensure that actions to improve on performance measures are robust, are actioned appropriately and are discussed at the relevant meetings to ensure senior level and board oversight as necessary.
- Ensure a holistic approach to the monitoring of safety and performance data, supported and informed by robust, ongoing clinical audits in all services underpinned by robust action plans to drive improvements.
- Ensure that staff receive appropriate safeguarding training to protect both adults and children.
- Ensure that both nursing and medical staff have appropriate mandatory training to keep people safe.
- Continue to review and put in place measures to address and manage patient access and flow, and ensure patients are appropriately discharged, working closely with system partners to achieve workable

solutions to the current barriers, including a review of the effectiveness of system wide GOLD calls and the steps taken in advance of anticipated busy periods to plan for this.

- Ensure that designated leaders have the time and capacity to lead effectively and manage governance within their divisions, departments and teams.
- Review using the emergency department as an access point for medically expected and surgical patients to relieve pressure on the whole system, reduce breaches of patient privacy and dignity, and improve the response to patients.
- Ensure that there is appropriate medical oversight and accountability for neurology patients on Tintagel ward including at weekends.
- Find a workable solution to delays in the administration of medicines to patients in the emergency department, and ensure that medicines in the medical division are stored safely and securely.
- Ensure there is a sustained and effective improvement in the management of sepsis in the emergency department.
- Ensure there is evidence in the emergency department of governance for equipment and the environment, which includes staff competence, cleaning regimes, availability of call bells in all areas, and maintenance being undertaken when required.
- Ensure that resuscitation trolleys in the medical division are checked appropriately so they are safe to use.
- Ensure that medical records remain secure and locked away throughout the medical division.

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors</p> <p>Fit and Proper Persons Requirement (FPPR)</p> <p>The processes in place to meet the Fit and Proper Persons Requirements for Directors (FPPR) were not sufficient to meet the requirements of the regulations and do not provide appropriate assurances that adequate checks are being made and recorded to confirm directors are suitably 'fit and proper'.</p> <p>We found that there was not a robust or effective policy or associated processes in place to ensure compliance with this regulation. We found breaches in compliance for some executive and non-executive directors currently in post.</p>

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>9(1) The care and treatment of service users must –</p> <p>(a) be appropriate,</p> <p>(b) meet their needs.</p> <p>Due to available bed pressures elsewhere in the hospital, pressures in the wider healthcare economy, and the requirement to receive expected medical and some surgical patients in the emergency department, not all patients were being treated in a timely way. The trust had not met the target to admit, discharge or transfer 95% of patients within four hours from arrival for at least the past two years.</p>

Regulated activity	Regulation
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This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

10(1) Service users must be treated with dignity and respect.

10(2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular –

(a) ensuring the privacy and dignity of the service user;

Due to overcrowding in the emergency department, patients waiting in the corridor on trolleys were not afforded the privacy and dignity they must have at all times.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12(1) Care and treatment must be provided in a safe way for service users.

12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –

(a) assessing the risks to the health and safety of service users of receiving the care or treatment;

(b) doing all that is reasonably practicable to mitigate any such risks;

Incidents that affect the health, safety and welfare of people using services must be reported internally and to relevant external authorities/bodies. They must be reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.

We found multiple incidents which were reported as ‘no harm’ which should not have been. These incidents included serious harm caused to patients and several which resulted in patient death.

Requirement notices

The emergency department was not yet providing sepsis management that was fully compliant with treatment protocols.

(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

We found that processes to ensure that resuscitation equipment was safe were not being followed. There were multiple occasions where daily and weekly checks had not been completed appropriately putting patients at risk.

The emergency department was not able to demonstrate staff were competent to use equipment. There were incomplete records to show equipment was cleaned as required. The patient call bells were sometimes not in the reach of patients, and were either not provided or not within reach in a number of the toilets provided for patients and visitors.

(g) the proper and safe management of medicines;

Staff on The Medical Admissions Unit did not follow the policies and procedure for managing medicines. We found that medicines were not stored securely on this ward

Not all medicines were given at the right time and there was a lack of safe management in all of medicines held in the clinical decision unit in the emergency department.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

We found systems and processes to manage governance at the trust were not clearly articulated and were not documented so that staff could follow them. We were

Requirement notices

unable to identify clear reporting or subcommittee structures. Governance systems were weak. The trust was in a period of transition to new processes but these were not well articulated and there was confusion about roles and responsibilities.

(2) Without limiting paragraph (1), such systems of processes must enable the registered person, in particular, to-

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

The provider did not operate effectively to reduce the risk to patients who were subject to delayed transfers of care.

There were significant numbers of patients requiring transfer out of the hospital. These patients were at risk of physical and mental deterioration, acquiring a pressure ulcer and acquiring a hospital-acquired infection.

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying on of the regulated activity;

The provider did not have sufficient processes in place to enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.

The divisional team and the board did not have sufficient oversight of risks. Risks were not reviewed often enough and significant risks were not always recognised or escalated appropriately. When concerns were escalated to the senior team, staff on the ground said there was limited action to mitigate them.

The provider was not able to demonstrate sufficient evidence through its governance and management of the service that it recognised, addressed and improved risks, safety and quality of care. There was a lack of

Requirement notices

action around some of the themes emerging from our inspection. This included avoidable patient harm, progress and results from clinical audit, and demonstrable learning from incidents, complaints and other indications of emerging or existing risks.

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

We found on the Medical Admissions Unit and on Tintagel Ward there were multiple occasions where patient records were left unlocked and unattended.

Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.

There were not sufficient numbers of staff on wards. This was due to high vacancy rates, difficulties in acquiring additional staffing and redeployment throughout the trust. Both patients and staff were feeling the impact of this.

Many staff in the medicine directorate did not have appropriate training in children's safeguarding level one or level two. Consultants employed by the trust did not have appropriate training in infection control, fire safety, health and safety, information governance and manual handling.

Many nursing and medical staff did not have appropriate levels of mandatory training to keep people safe.

There was not adequate specialist cover for neurology patients at the weekends. The nurses did not receive additional training to ensure they had the skills necessary to care for neurology patients safely. The nurses did not have the support they needed to care for these patients safely.