Care Quality Commission

Royal Cornwall Hospitals NHS Trust

West Cornwall Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Surgery	Good
Outpatients and diagnostic imaging	Good

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 serves a population of around 532,273 people, a figure which can be doubled by holiday makers during the busiest times of the year.

West Cornwall Hospital is a registered location of Royal Cornwall Hospitals NHS Trust and is located in Penzance. It provides medical inpatient, day surgery, urgent care and outpatient services. This was an announced focused inspection of West Cornwall Hospital. We inspected both surgery and outpatient services as part of this inspection. We visited West Cornwall Hospital on 5 July 2017.

We rated West Cornwall Hospital as good overall.

Our key findings were as follows:

- Staff reported incidents and demonstrated knowledge of how to do this. They could explain the learning and actions which had resulted from incidents, near misses and never events. They were confident in the processes to identify and report incidents.
- The environment was well maintained and was visibly clean and tidy. Staff adhered to infection control policies and procedures.
- Equipment was in working order and had been serviced/calibrated as required. Resuscitation equipment was checked regularly.
- There were arrangements to safeguard vulnerable adults and children from abuse, which reflected the relevant legislation and local requirements.
- Staff monitored patients for signs of deterioration and were confident in the process to follow and escalation route should a patient deteriorate or be identified for sepsis.
- Compliance with the five steps to safer surgery World Health Organisation checklist was observed in theatres. Checklists were appropriately adapted to suit the procedure.
- Care and treatment was delivered in line with relevant evidence-based best practice guidance and standards.
- All outpatient staff were competent to carry out their roles. Learning needs were identified during their annual appraisal and the trust encouraged and supported continued professional development.
- Patients were positive about the care and treatment they had received. We observed staff treating patients with compassion and kindness. We saw staff did everything possible to ensure that patients' privacy and dignity was respected.
- Staff understood and respected patients' personal, cultural, social and religious needs.
- Staff showed a supportive attitude to patients. When patients showed discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way.
- Staff kept patients well informed throughout the pathway, ensuring their understanding and consenting patients verbally and with written consent.
- Patient flow from admission to discharge was timely, with minimal delays. However, the full capacity of theatres at West Cornwall Hospital was not being fully utilised.
- Information about the needs of the local population was used to inform how services were planned and delivered.
- Patients' individual needs were taken into account, For example, people with learning difficulties, patients living with dementia, mobility problems, hearing difficulties and visual impairment may be given longer appointment times.
- There was a clear vision for surgical services at West Cornwall Hospital, however the strategy for achieving this was dependent on the review of the current infrastructure.

Summary of findings

- There was a very positive culture in surgical services and all of the outpatient departments we visited. The local management teams were well respected. Managers supported their teams and promoted good quality care and were comfortable in raising concerns and issues. The departments we visited appeared well organised and were running smoothly.

We also saw areas of outstanding practice, including:

- There was a very positive culture in all the departments we visited. Staff described good teamwork and flexibility within the staff groups.
- Staff across all of the outpatient departments and we visited, including reception staff were very patient-centred and made great efforts to ensure patients were supported, given time to ask questions and understood the information they had been given.
- The department had six volunteers. We saw them helping people around the department and to different parts of the hospital. We saw them spending time with patients who were waiting, helping to relieve their anxiety. The volunteers also provided drinks to patients who were waiting for their appointments. The outpatient department manager spoke very highly of their volunteers and the positive effect they had on patients who visited the department.

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

Importantly, the trust must:

- Review all equipment in the surgical unit and theatres at West Cornwall Hospital and ensure it is serviced in line with manufacturer guidance. The asset registers should ensure a clear audit trail is maintained of date of last service and date due for next service.

In addition the trust should:

- Ensure all staff are aware of the local procedure at West Cornwall Hospital for managing patients requiring overnight stay or transfer for escalation of care and ensure this process is well embedded and staff are able to access advice immediately if a patient is at risk. The surgeon and anaesthetist should be reminded to visit the ward to check all patients prior to them leaving site and handover to the medical team on site in line with the local procedure. The arrangements with the ambulance service and timely transfer of patients should be reviewed to ensure there are no risks to the patient and staff are not left feeling vulnerable.
- Ensure staff are confident in the response to emergencies through the use of simulation scenarios and use these to identify learning needs for processes and staff.
- Review the use of fabric reusable curtains in the surgical unit and the diagnostic imaging department and their implications on infection prevention control within the hospital.
- Consider a formal process for clinical supervision to ensure improvements in nurse practice and reflective learning.
- Continue to review the capacity at West Cornwall Hospital and the opportunities to increase theatre lists for the benefit of improving flow at Royal Cornwall Hospital and ensuring patients receive timely operation dates.
- The trust should ensure there are processes in place for induction and orientation when West Cornwall Hospital staff are relocated to Royal Cornwall Hospital for their shift. Consideration should be given to the safe staffing provided when staff are required to work on wards or departments which they have never experienced or are not comfortable to work in.
- Review the process for recording and managing risks relevant to theatres and the surgical unit at West Cornwall Hospital.
- Monitor the risks and practices put in place to reduce the risks for radiography staff when lone working out of hours.
- Make better use of the cardiology clinic capacity available at West Cornwall Hospital.
- Make data available, trust-wide, to show the proportion of patients that waited more than 30 minutes to see a clinician or what percentage of clinics started late.
- Display information about chaperones being available in all outpatient areas.

Summary of findings

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Good	We rated this service as good because:

- Staff could explain the learning and actions which had resulted from incidents, near misses and never events. They were confident in the processes to identify and report incidents.
- The environment was well maintained and was visibly clean and tidy. Staff were observed to follow good infection prevention and control practice.
- Staff monitored patients for signs of deterioration and were confident in the process to follow and escalation route should a patient deteriorate or be identified for sepsis.
- Compliance with the five steps to safer surgery World Health Organisation checklist was observed in theatres. Checklists were appropriately adapted to suit the procedure.
- Care and treatment was delivered in line with legislation, standards and evidence based guidance.
- Patients were positive about the care and treatment they had received. We observed staff treating patients with compassion and kindness. Staff always respected patient privacy and dignity.
- Staff kept patients well informed throughout the pathway, ensuring their understanding and consenting patients verbally and with written consent.
- Patient flow from admission to discharge was timely, with minimal delays. However, the full capacity of theatres at West Cornwall Hospital was not being fully utilised.
- There was a positive culture where staff were comfortable in raising concerns and issues, staff felt the local leadership team were approachable and supportive.
- There was a clear vision for surgical services at West Cornwall Hospital, however the strategy for achieving this was dependent on the review of the current infrastructure.

However:

Summary of findings

- Equipment was not always maintained in line with servicing requirements and therefore did not keep people safe. The clinical equipment inventory did not provide a clear audit trail of date of required service in line with manufacturer guidelines.
- Nursing staff were not always able to access fast advice once consultants had left the site and did not have immediate medical support. This left staff feeling vulnerable and posed a risk if a patient should quickly deteriorate.
- There was not a clear arrangement with the ambulance service for the transport of a deteriorating patient. This caused delays in transfer as the hospital was seen as a place of safety and therefore not prioritised.
- Not all consultants visited patients and the nursing staff on the surgical unit before leaving site despite this being part of the local procedure for surgical services at West Cornwall Hospital.
- We were unable to evidence the completion of simulation scenarios to respond to patient emergencies.
- Fabric reusable curtains did not have a clear cycle for deep cleaning, this posed an infection risk.
- The theatres at West Cornwall Hospital were not being fully utilised with a number of cancellations. One theatre was not being utilised at the time of our inspection due to a consultant cancelling and no other consultant capacity to run an additional list.
- We were not provided with the assurance that risks were being identified, managed and recorded effectively.

Outpatients and diagnostic imaging

Good

We rated this service as good because:

- People were protected from abuse and avoidable harm.
- People were supported, treated with dignity and respect and involved as partners in their care.
- Care and treatment was delivered in line with evidence based best practice guidance.
- Staff were competent in their roles and attended training regularly.
- People's needs were met by well organised and well managed services.
- We saw and heard about person centred care.
- There was a positive, open and fair culture.

Summary of findings

However:

- Fabric curtains as opposed to disposable curtains were used in the diagnostic imaging departments, which could pose an infection control risk.
- There were two cardiology clinics timetabled each month at West Cornwall Hospital which were very rarely utilised due to a lack of cardiologists available to run the clinic.

West Cornwall Hospital

Detailed findings

Services we looked at
Surgery;Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to West Cornwall Hospital

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in the county of Cornwall. The trust serves a population of around 450,000 people, a figure that can be doubled by holiday makers during the busiest times of year.

West Cornwall Hospital is a registered location of Royal Cornwall Hospitals NHS Trust and is located in Penzance.

It provides medical inpatient care for older people and day case surgery, as well as diagnostic and therapy services and a wide range of outpatient clinics. The hospital also has a 24-hour urgent care centre and a satellite dialysis unit.

Our inspection team

Our inspection team was led by:

Chair: Graham Nice, Managing Director of an Independent Healthcare Management Consultancy

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

Inspection Manager: Julie Foster, Care Quality Commission

The West Cornwall Hospital team included CQC inspectors, inspection manager and a variety of specialists including a theatre nurse and a radiologist.

How we carried out this inspection

Prior to the inspection we reviewed a range of information we hold about the hospital and the trust in general, including information from Healthwatch Cornwall and Kernow Commissioning Care Group.

We requested a range of data from the trust to demonstrate their performance. We carried out an announced inspection of the trust between 4 and 7 July 2017 and visited West Cornwall Hospital on 6 July 2017 to inspect surgical services and outpatients and diagnostic imaging.

We held a drop-in session to which all grades of staff in the hospital including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, staff side representatives, domestic staff and porters were invited. We also spoke with staff individually. In total we spoke with 29 members of staff. We spoke with eight

Detailed findings

patients who were attending the hospital, and two relatives. Additionally, we made telephone contact with two patients and one relative who had recently used the surgical services at the hospital to gain their feedback.

We observed how people were being cared for and reviewed patients' records of their care and treatment.

Facts and data about West Cornwall Hospital

The West Cornwall Hospital provides medical inpatient care for older people split across two wards. Day case surgery is provided in two theatres and a 16-bedded surgical unit. There is a renal unit and endoscopy suite, as well as diagnostic and therapy services and a wide range of outpatient clinics. The hospital has a 24-hour urgent care centre which is a type three doctor led service.

The trust provides an average of 1,283 outpatient clinics per week, seeing an average of 10,155 patients per week across 36 specialties. The trust outpatient services deliver a variety of clinic types, including traditional consultant-led clinics, one-stops, rapid access, virtual, telephone, see & treat, nurse and therapy run and multi-professional clinics across the county.

Between July 2016 and June 2017 there were 42,884 outpatient appointments and 25,060 diagnostic procedures (X-rays) carried out at West Cornwall Hospital.

Since its registration with the Care Quality Commission West Cornwall Hospital has been inspected six times between 2011 and 2016, this is their seventh inspection.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

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

Surgery

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

Information about the service

Surgical services are provided at West Cornwall Hospital to include ophthalmology, urology, gynaecology, and general surgery for elective day case patients who are pre-assessed against admission criteria. Between January and May 2017 1798 day case patient operations were completed and 105 were inpatients with an average length of stay of 0.21 days.

There are two operating theatres, one recovery ward and one 16 bedded nurse led day case ward split as an eight bedded male and an eight bedded female side. Some procedures were also completed in the treatment centre which included areas suitable for minor surgery.

We visited the hospital for one day, and spent time in theatre and on the surgical unit, we also visited the treatment centre. We spoke with 18 staff to include; hospital manager, hospital clinical matron, acting ward manager, acting theatre manager, nurses, health care assistants, operating department practitioner, consultant anaesthetist, cleaners and pharmacists.

We observed patient care and obtained feedback by talking to four patients and two relatives on the surgical unit during the inspection. We spoke to a further two patients and one relative over the telephone following the inspection. We reviewed nine patient records. Both prior to and following the inspection we reviewed data and information provided by the trust and hospital.

Summary of findings

We rated this service as good because:

- Staff could explain the learning and actions which had resulted from incidents, near misses and never events. They were confident in the processes to identify and report incidents.
- The environment was well maintained and was visibly clean and tidy. Staff were observed to follow good infection prevention and control practice.
- Staff monitored patients for signs of deterioration and were confident in the process to follow and escalation route should a patient deteriorate or be identified for sepsis.
- Compliance with the five steps to safer surgery World Health Organisation checklist was observed in theatres. Checklists were appropriately adapted to suit the procedure.
- Care and treatment was delivered in line with legislation, standards and evidence based guidance.
- Patients were positive about the care and treatment they had received. We observed staff treating patients with compassion and kindness. Staff always respected patient privacy and dignity.
- Staff kept patients well informed throughout the pathway, ensuring their understanding and consenting patients verbally and with written consent.

Surgery

- Patient flow from admission to discharge was timely, with minimal delays. However, the full capacity of theatres at West Cornwall Hospital was not being fully utilised.
- There was a positive culture where staff were comfortable in raising concerns and issues, staff felt the local leadership team were approachable and supportive.
- There was a clear vision for surgical services at West Cornwall Hospital, however the strategy for achieving this was dependent on the review of the current infrastructure.

However:

- Equipment was not always maintained in line with servicing requirements and therefore did not keep people safe. The clinical equipment inventory did not provide a clear audit trail of date of required service in line with manufacturer guidelines.
- Nursing staff were not always able to access fast advice once consultants had left the site and did not have immediate medical support. This left staff feeling vulnerable and posed a risk if a patient should quickly deteriorate.
- There was not a clear arrangement with the ambulance service for the transport of a deteriorating patient. This caused delays in transfer as the hospital was seen as a place of safety and therefore not prioritised.
- Not all consultants visited patients and the nursing staff on the surgical unit before leaving site despite this being part of the local procedure for surgical services at West Cornwall Hospital.
- We were unable to evidence the completion of simulation scenarios to respond to patient emergencies.
- Fabric reusable curtains did not have a clear cycle for deep cleaning, this posed an infection risk.
- The theatres at West Cornwall Hospital were not being fully utilised with a number of cancellations. One theatre was not being utilised at the time of our inspection due to a consultant cancelling and no other consultant capacity to run an additional list.
- We were not provided with the assurance that risks were being identified, managed and recorded effectively.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- Equipment was not always maintained in line with servicing requirements and therefore did not keep people safe. The clinical equipment inventory did not provide a clear audit trail of date of required service in line with manufacturer guidelines.
- The lack medical staffing for the surgical unit, following completion of theatre lists, posed a risk if a patient deteriorated. Although processes were in place staff were not always able to access fast advice.
- Staff were not clear on the arrangements with the ambulance service to transport deteriorating patients to Royal Cornwall Hospital. Staff reported delays in transfer from West Cornwall Hospital because it was seen as a place of safety and therefore not prioritised.
- Staff told us not all consultants visited patients following completion of their theatre lists. This left staff feeling vulnerable and was not consistent with the local flow chart.
- We were unable to evidence the completion of simulation scenarios to respond to patient emergencies.
- Fabric reusable curtains did not have a clear cycle for deep cleaning, this posed an infection risk.

However:

- Staff were confident in the processes to follow to identify and report an incident.
- Theatres and the surgical unit were visibly clean and tidy. Staff were observed to follow good infection prevention and control practice.
- Regular observations were completed for patients to enable nursing staff to identify if a patient is deteriorating. There was a good knowledge amongst staff of sepsis protocols.
- Resuscitation equipment was observed to be maintained in good working order and regular checks were completed to ensure it was ready for use in an emergency.
- In theatres good practice was observed with the completion of the five steps to safer surgery World Health Organisation checklist.

- Medicines were stored securely and handled and administered safely.
- Theatre and nursing staffing levels and skill mix was planned in line with the service needs. Staffing was as planned during our inspection.

Incidents

- Five never events had been reported within the surgery service for the trust between October 2016 and June 2017. None of these five occurred at West Cornwall Hospital, however staff were aware of these never events and trust wide learning was shared. Staff spoke to us about a near miss at West Cornwall Hospital, whereby the wrong eye was prepared. This near miss was identified through the use of the World Health Organisation (WHO) surgical checklist before the procedure began. Staff explained the change in practice as a result of this near miss, now preparation does not begin until after the time out section of the WHO surgical checklist has taken place.
- Staff understood their responsibilities to raise concerns and record safety incidents, and said they were encouraged to do so. Staff were able to explain the process to report incidents and explained the type of incidents which were reportable. They said they received learning, where applicable, to incidents they have raised or trust wide incidents.
- Trends for incidents reported at West Cornwall Hospital included the rare occasions when patients were not suitable for surgery and therefore surgery has been cancelled, problems resulting from decreased cleaning cover and support with teas and coffees on the surgical unit, needle stick injuries and the theatre environment being too hot or too cold.
- Mortality and morbidity meetings were held for each speciality on a monthly basis and these fed in to service improvement. The speciality team discussed cases using a presentation, meetings were well attended and we saw evidence of lessons learned. The mortality review was shared with each speciality within their governance newsletters. Patients were rated using a classification method in order to rank a complication in an objective and reproducible manner. We saw examples of morbidity and mortality with good quality information presented and actions identified.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Staff we spoke with had a variable level of understanding of the terminology duty of candour. However, they were aware of the need to be open and honest with the patient about what had happened and further actions that needed to be taken.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained. Systems were in place to protect people from healthcare associated infection however, it was not clear if some systems were being used in a reliable and consistent way.
- The areas of the hospital we visited were visibly clean, tidy and well maintained. This included equipment, corridors, bed spaces and staff rooms. Staff were aware of the items that had been cleaned by the use of 'I am clean' stickers, these were observed to be recently dated.
- Responsibility for the cleaning of the wards and theatres was shared between contracted cleaners and nursing/ theatre staff. Due to vacancies within the contracted cleaning team, cleaning staff were only available between 6am and 2pm rather than from 6am to 7pm. This meant after 2pm the responsibility for cleaning the surgical unit and theatres fell to the nursing and theatre staff, the full theatre list was therefore not covered. Cleaning staff we spoke to felt the lack of staffing was impacting on the standard of cleanliness. Concerns were raised by staff whether the cleaning arrangements were satisfactory in theatres without the full day cover and the implications this may have on infections.
- The use of fabric, reusable curtains, rather than disposable on the surgical unit posed an infection control risk. This is not best practice for infection prevention and control. Curtains appeared clean but there was no easily visible date on them showing when they were last cleaned, or when they needed to be cleaned again. We asked a cleaner the regularity of these being cleaned and were told these were inspected

weekly to check for spillages and changed when needed. We were told they should be cleaned in June and December each year however there was no record of this and we were told this was not always achieved.

- We saw signed cleaning checklists for specific rooms, however we were informed the completion of day to day checklists had stopped the week before and those still in use were wiped at the end of each week or month so there was no historical record of cleaning being carried out. Therefore we could not be assured that cleaning was consistently being done.
- Joint cleaning audits were undertaken by both nursing and cleaning staff to assess for compliance. The most recent result for June 2017 showed a compliance of 98%.
- Staff were compliant with infection control practices to prevent the spread of infection as per National Institute for Health and Care Excellence. This included; washing hands between patients, being bare below the elbow and use of personal protective equipment to include aprons and gloves. Alcohol gel and wash basins were available and clearly sign posted for staff, visitors, and patients, to use near the entrance of the hospital and each ward as well as bed spaces.
- Hand hygiene audits were completed monthly. In May 2017 100% compliance was achieved for theatres, theatres recovery and the surgical unit. In June 2017 theatres were 100% compliance and the surgical unit was 94% compliant.
- Theatres were compliant with the National Institute of Health and Care Excellence guidance preoperative, intraoperative and postoperative phases for best practice in infection prevention and control. For example preoperatively patients were asked to remove all jewellery and were in appropriate theatre wear. Patient prophylactic antibiotics were used, these antibiotics help to prevent infections at the surgical site. Intraoperatively we observed antiseptic skin preparation which was allowed to dry before surgical draping, sterile drapes were correctly placed and following surgery dressings were applied around the wound site before drapes were carefully removed. When observing in theatre the sterility of the surgical sterile field was well maintained.
- Patients were screened for MRSA as part of their pre-assessment. This reduces the risk of patients getting an MRSA infection or passing it on to other patients. During our inspection we found in all six records reviewed patients were appropriately screened for MRSA as part of the infection control risk assessment. Based on available evidence not all patients are routinely screened for MRSA to include day case ophthalmology and day case dental patients.
- An infection prevention and control theatre audit tool was in place, in March 2017 West Cornwall Hospital Theatres were audited by an infection prevention nurses and were 97% compliant. Recommendations included cupboards in one anaesthetic room were poorly fitted and damaged, this was reported to estates, and disposable patient cups, face masks and suction catheters were stored in dirty utility, action was to remove these items.
- The cleaning of linen was carried out by an external organisation. Linen would be collected, stored and then collected by the other organisations. Clean linen would then be returned. Staff reported both the collection and return was timely and responsive to needs.
- Theatre equipment was always sterilised and decontaminated between patient use. The sterile services department was based off site at the Royal Cornwall Hospital. Sterile theatre equipment was requested and made available for theatre lists and was returned to the sterile services department following use.
- Surgical specialities held a monthly audit meeting where infection risks were discussed. The readmission report was used to identify any surgical site infections and was reviewed by speciality teams. Surgical site infections were discussed at the monthly audit meetings enabling the identification of any trends.

Environment and equipment

- We were not assured the maintenance of equipment was keeping people safe. The date of service label on some equipment indicated it had expired its service date. The trust maintained an inventory of clinical equipment, we requested a copy for the surgical unit and theatres at West Cornwall Hospital, we found this did not provide a clear audit trail and equipment appeared to require servicing.
- The theatre asset list contained 104 pieces of equipment, for 77 (74%) pieces of equipment there was no date of last service and no date to indicate when

servicing was next required. For example the operating table, scopes and patient monitors. It was not clear if these required a service or when they would require servicing.

- Eight pieces of equipment were last serviced in 2013, 2014 or 2015 to include infusion pumps, gases and agent analyser, pressure therapy, flowmeter, non-invasive blood pressure and diathermy. It appeared only 19 pieces of equipment had been serviced within the last year. We confirmed all anaesthetic machines had been serviced in the last year.
- For the 27 items of clinical equipment on the surgical unit seven electronic thermometers and one electric bed had no date or information to indicate when servicing was required. Two pieces of equipment to include suction device and non-invasive blood pressure were last checked in 2013 or 2015. Four pieces of equipment had been serviced just over a year ago. There were 13 pieces of equipment which had been serviced within the last year.
- Resuscitation equipment was available, fit for purpose and checked regularly. This ensured it was ready for use in an emergency. Staff completed daily checks to ensure the tag was sealed and weekly checks to confirm all equipment was available and in date. We saw evidence of these checks being completed recorded in a designated book. We performed a random check of equipment and found equipment was in good condition and in date. The resuscitation team had also completed an audit of the resuscitation trolleys the week before our inspection.
- Anaesthetic equipment was checked daily in line with the Association of Anaesthetics of Great Britain and Ireland guidelines to ensure the correct functioning of the anaesthetic equipment prior to use to ensure patient safety.
- Sterile instrument sets for operations were provided from the sterilising department at Royal Cornwall Hospital. Sterile instrument sets were ordered in advance and in adequate quantities to facilitate the smooth running of lists. However, staff told us sterile instruments sets sometimes arrived with holes due to transporting, therefore compromising sterility. This was reported as an incident. The risk was being mitigated by closely monitoring the lists and over ordering equipment to ensure the there is no impact on the lists. Emergency sets and sundries were readily available in the preparation room.
- Surgical unit and theatre stock and consumables was stored in an orderly fashion. A random check on the surgical unit identified two boxes of female urinary catheters which had expired five months and one month prior to our inspection. These were unlikely to be used for patients as catheters were generally placed in the theatre department.
- The environment was designed and maintained to keep people safe. There were clear routes for fire exits. The theatre department had a clear corridor to ensure safe access for staff and patients, access to the theatre was secured.
- The theatre ventilation was problematic and could be too hot or too hot. The engineer needed to be contacted via the main site, rather than directly which prolonged the response. Managers told us this had been escalated.
- Clinical waste was well managed with the use of clinical waste bins or containers being used. None of the waste bins or containers we saw on the ward were unacceptably full. Each bin was clearly labelled in to domestic and clinical waste.

Medicines

- Medicines were stored securely and safely handled and administered. Medicines on the surgical unit and in theatres were locked at all times and keys were held with a responsible person.
- Controlled drugs were safely used and managed. We checked controlled drug stock against the controlled drug registers and confirmed these to be correct. The ordering, receipt and administration of controlled drugs was clearly recorded, and completed in accordance with legal and professional requirements. Daily controlled drug checks were completed and signed. On the surgical unit we reviewed the completion of the controlled drug weekly checks and this was mostly completed with one absent signature in June 2017 and three absent signatures in May 2017.
- Nursing staff administered controlled drugs safely, checking the patient name and date of birth before administering, and observing the patient taking the medication.
- We performed a random check of medicine stock and all medicines checked were in date.

- Fridge temperatures were monitored, either through daily checks or an electronic link to pharmacy who identified any changes to temperature or faults with the fridge. Staff told us how pharmacy call if they identify a fault with the fridge to ensure this is investigated immediately.
- Electronic prescription charts were used for recording patient medication and administration. This clearly identified the time and dose of medication administered. We were told the anaesthetic records were not always added electronically and instead recorded on paper charts. This meant information was not all in the same place and nursing staff had to ensure they checked both records.
- Allergies were clearly documented within patient documentation and electronic prescription charts. On admission nursing and medical staff confirmed any patient allergies, medical history and medication with the patient.
- Medical gases were safely stored in purpose made holders above floor height.
- Pharmacy support was available on site. Pharmacy completed short dated expiry checks on a regular basis. Pharmacy replenished stock and were able to provided medications if not available from ward stock. An annual safe storage of medicines audit was completed by pharmacy and monthly medicine audits were completed by ward staff.

Records

- Records were stored securely to ensure patient confidentiality. Records available for patients on the surgical unit were held under key pad lock. This system was well embedded with all cabinets we looked at being locked and secure, and immediately closed after use. Discharged patient records were held securely while awaiting return to Royal Cornwall Hospital records department or relevant hospital for their outpatient clinic appointment.
- Individual patient care records were accurate, mostly complete, legible and up to date. We reviewed six patient records. We did find one record which was not fully complete, it did not include the review with senior clinician post-surgery and not all pre-operative assessments were dated.
- We reviewed three sets of records being completed in theatres. All relevant information was completed in line with the procedure, signed and dated.
- Risk assessments were completed for each patient. This included; infection control, falls, pressure ulcer, venous thromboembolism, nutritional, manual handling and bed rails.
- Both medical and nursing staff completed relevant documentation and notes within the patient records.
- Tracking labels were added to patient records to ensure identification of the equipment used.

Safeguarding

- Staff were confident in the systems, processes, and practices for safeguarding. Staff understood their responsibilities and adhered to trust policies and procedures.
- Staff had knowledge of the safeguarding leads within the trust and were able to contact them if they had any uncertainty or concerns. Staff also provided an example of how the safeguarding team contacted the surgical team at West Cornwall Hospital to inform them of a patient who was attending and had a safeguarding flag and to assure them they were available for support if required during the admission.
- Nursing registered and additional clinical staff in theatres and on the surgical unit complete safeguarding training level one and two for both adults and children. Training records dated 31 May 2017 showed staff compliance with safeguarding training level one was 100%. Level two training was at 91% for adults and 88% for children.
- Female genital mutilation awareness training was included as part of the safeguarding training.

Mandatory training

- The trust target for local and mandatory training was at 95%. Data was provided dated 31 May 2017. For the theatre and surgical unit, registered nursing and additional clinical staff at West Cornwall Hospital, 100% compliance was achieved for equality and diversity, manual handling (both patient and non-patient), medicines management, mental capacity act, and safeguarding level one adults and children. There were a few gaps in full staff completion for fire safety (82% - six people not up to date), health and safety (82% - six people not up to date), resuscitation adult basic life support (84% - five people not up to date), information governance (88% - four people not up to date) and safeguarding level two adults (91% - three people out of date) and children (88% - four people out of date).

- Mandatory training was available online or face to face. Staff said it was difficult to find time to complete mandatory training and the online system is unworkable and doesn't always capture training completed. This resulted in staff needing to complete the training for a second time. Managers told us the electronic staff record is difficult and there are delays, between six to 12 weeks, showing information despite the information being put on and therefore skewing data.

Assessing and responding to patient risk

- Although risks to people who use the service were being assessed and monitored, there were potential risks to patient safety. Concerns were raised by staff if a patient should deteriorate due to the lack of medical infrastructure, and certainty of the processes to follow and the support available.
- An admission criteria for patients ensured only patients with stable medical conditions were treated at West Cornwall Hospital, reducing the risk of complications during or following surgery. The admission criteria was based on patient physical status classification, approved by American Society of Anaesthesiologists (ASA). Patients could receive their elective treatment at West Cornwall Hospital if they were classified as ASA1; a normal healthy patient, or stable ASA2; a patient with mild systemic disease. West Cornwall Hospital did not have a high dependency unit or a stable medical infrastructure to treat patients outside of ASA1 and stable ASA2 classification.
- Although patients were low risk, there was a potential risk to patient safety if a patient should deteriorate due to the lack of medical cover and consultant availability once theatre lists had finished. Some consultants and anaesthetists left quickly after their lists without visiting patients on the wards. Staff we spoke with were able to describe the processes involved when managing a deteriorating patient. There were clear pathways and processes for this. There was a trust wide policy named 'clinical policy for safe transfer of patients between care areas or between hospitals' and a local flow chart for West Cornwall Hospital. If a patient was deteriorating staff would bleep the anaesthetist, if on site, or the on call urgent care doctor. There was also access to the junior doctor who covered the medical wards at West Cornwall Hospital and the on call surgeon based at Royal Cornwall Hospital if required. However, nursing staff felt vulnerable once the consultant medical team were no longer on site, they said the junior doctors on site were not always responsive and although there were processes for escalation it took time and therefore they could not always get fast advice.
- On review of the local flow chart procedure for managing patients requiring overnight stay or transfer for escalation of care it states 'surgeon and anaesthetist visit the ward to check all patients prior to leaving. The surgeon should hand over any patients still in the unit to the medical team on site. The surgeon/anaesthetist inform the nurse they are leaving the building. Nurse informs West Cornwall Hospital bleep that the surgical ward has become nurse led.' We were not assured these processes were embedded. This flow chart was not displayed on the surgical unit, when staff were asked they were aware of a procedure in place but could not locate it.
- The hospital crash team would respond to a crash call. Staff were not aware of practicing a resuscitation scenario. We requested a copy of resuscitation practice or scenario report and any learning or recommendations, this was not provided for West Cornwall Hospital.
- In an emergency situation we were told patients would be transferred by ambulance to the Royal Cornwall Hospital, by dialling 999. However the flow chart indicates a different number to contact if an urgent ambulance transfer is required with specific information to state. Consultant anaesthetists, if on site, would accompany patients if they were intubated. Staff told us they could wait up to two hours for an ambulance as the hospital is seen as a place of safety and therefore was not prioritised. Staff were not aware of arrangements with the ambulance service to ensure this transfer was timely. One example was provided of an ambulance arriving at the hospital and then being diverted to an urgent call. We were provided with a copy of an information bulletin dated 1 April 2017 for both St Michaels Hospital and West Cornwall Hospital on how to request an urgent transfer from the ambulance service. We were also told although there was no service level agreement with the ambulance service, requests for transfer were made in line with trust policy and patients were medically assessed regarding clinical condition and urgency of transfer required.
- On review of data between 1 January and 11 July 2017 there were seven transfers from West Cornwall Hospital

to Royal Cornwall Hospital, all patients had left recovery at West Cornwall Hospital prior to decision to transfer. For the seven of these transfers the time between confirmation of transferring patients out of West Cornwall Hospital and arriving at Royal Cornwall Hospital was one hour and six minutes, this appeared timely considering the distance of travel required.

- A pre-operative assessment was completed for each patient, which was either a face to face or telephone assessment at one of the trust sites. The face to face assessment also included an occupational therapy assessment to assess if any equipment is required post operatively. Assessments included height, weight, blood pressures, bloods, electro cardio gram, spirometry and MRSA screening. If there is a time lag between the assessment and the operation a top up triage call was completed to ensure no changes to the patient's condition.
- The National Early Warning System (NEWS), an escalation trigger protocol, was used for all patients. Patients were monitored in theatre recovery and admitted to the ward once their NEWS was stable. On the wards the NEWS continued to be monitored. We saw evidence in patient records of NEWS completed.
- Staff were knowledgeable in sepsis management and how to identify sepsis using sepsis pathways. Sepsis is a common and potentially life threatening condition triggered by an infection.
- The five steps to safer surgery World Health Organisation (WHO) checklist was well conducted. All stages were signed and dated. The sign out was conducted by the consultant. We saw evidence of modified checklists which were available for cataract and pain intervention procedures.
- Pre-operatively medical staff reviewed patient records, checked their consent to the procedure and marked the surgical site or side.
- The trust completed monthly WHO audits through peer observation and review of completed WHO checklists. This was reported by site and speciality to enable trends to be identified. Between December 2016 and May 2017 compliance for West Cornwall Hospital on a monthly basis was 100% with the exception of March 2017 at 98%. As a result of a number of never events across the trust the process for auditing WHO compliance was revised and the new process commenced in June 2017. The new process requires the theatre management team to complete five WHO audits per month external to their base area using the safer surgery checklist audit tool.
- Safe practice was undertaken during care delivery in theatres. This included counting and recording of swabs, needles and instruments in accordance with the Association for Perioperative Practice (AfPP) guidelines. Staff safely transferred and repositioned patients.
- Team briefings were held at the start of each list to ensure all staff were up to date with any issues or concerns and prepared for the day.
- Blood was available and maintained by the blood transfusion department. We saw o negative blood was available. O negative blood cells are universal meaning they can be transfused to almost any patient in need. All staff who had access to blood must undertake online training before they can be responsible for blood collection.
- Staff monitored patient temperature in theatre and recovery. Warming devices were used in both areas.
- Clear and detailed information was provided when patients were handed over to staff. Both the anaesthetist and scrub nurse completed handover from theatre to recovery. Nurses would hand over from recovery to the ward.
- Comprehensive risk assessments were completed for patients preoperatively. To include; falls, pressure ulcers, nutritional, bedrails, venous thromboembolism (VTE) and manual handling. Staff told us the number of falls were low. If patients were known to have a pressure ulcer or their skin was compromised they were able to access pressure relieving equipment. VTE was recorded electronically and we observed patient's legs being measured for VTE stockings.
- Patients were asked if there was someone to pick them up and available at home following discharge, this ensured patient safety once they had left the hospital.
- If patient pain could not be controlled, or they were unable to overcome nausea and vomiting following surgery then patients required an overnight stay. Side rooms were available on medical wards at West Cornwall Hospital, and these were used approximately twice a month for surgical patients who required an extended stay. Patients could also be transferred to Royal Cornwall Hospital. However, staff said there were sometimes difficulties with bed availability.

Surgery

Nursing staffing

- Staffing levels and skill mix was planned and reviewed using relevant tools and guidance to ensure appropriate staffing levels for the theatre lists, and the number and acuity of patients on the wards, to ensure safe staffing levels. The ward manager told us they based and planned skill mix and staffing on the service need. There was rarely a need to use bank or agency. Existing staff were signed up to the bank and would provide additional cover as needed. However, the ward manager informed us the additional bank shifts were monitored to ensure staff wellbeing. Data in the 15 month period for April 2016 to June 2017 showed there were none, one or two whole time equivalent agency staff per month.
- The theatre rota was planned and agreed two to three months in advance. Any adjustments were made in full consultation with the team. Specialities were covered, with leads in specialities, to ensure the right staffing mix per session.
- Theatre staff covered the theatre lists, nursing staff covered the surgical unit 7am to 8pm Monday to Friday, and any Saturday lists. However, if a patient deteriorates and needs to stay in longer, or awaiting non-urgent transfer which can be a wait of over four hours, nursing staff may be required to stay with patients outside of their shift hours.
- At the time of our inspection there were no nursing or health care assistant vacancies on the surgical unit. Four full time vacancies were present within the theatre team and there had been difficulties in recruiting, however these were being recruited to.
- Staff told us they are sometimes required to work at Royal Cornwall Hospital, this was dependent on staffing levels across the trust. Staff said they could end up on any wards and some described this as “terrifying.”

Surgical staffing

- Consultant surgeons and anaesthetists and their appropriate medical team would attend for theatre lists. They would visit patients on admission, complete the procedure in theatre and most would visit the patients post operatively before leaving West Cornwall Hospital. However, staff said some consultant surgeons and anaesthetists will leave following completion of the theatre lists, without visiting the surgical unit nursing staff and patients, this left staff feeling vulnerable.
- West Cornwall Hospital had two medical wards which were covered by one junior doctor, this doctor could be contacted by nursing staff on the surgical unit if required for support. Nursing staff could also contact the on-call team at Royal Cornwall Hospital.

Major incident awareness and training

- There was a trust wide major incident plan and staff had good knowledge of the action and role that West Cornwall hospital would take in different scenarios. For example in the event of a major incident, West Cornwall would cancel its surgical list and prepare to accept any walking wounded. An incident grab bag was available in the hospital manager’s office and contained things for quick triage and laminated sheets with information about the actions to take as well as contact information.
- We reviewed the major incident folder which had been updated in February 2017.

Are surgery services effective?

Good

We rated effective as good because:

- Care and treatment was delivered in line with legislation, standards and evidence based guidance.
- Pain was well managed for patients and pain relief was administered promptly.
- Staff across the surgical unit and theatres worked well together to ensure care and treatment was delivered effectively for patients.
- There was an on-site pharmacy and pharmacist support available Monday to Friday.
- Staff consistently sought verbal and written consent from patients.

However:

- There was no clear programme of staff clinical supervision.

Evidence-based care and treatment

- Peoples’ needs were assessed and care and treatment delivered in line with legislation, standards and evidence based guidance. Policies and standard operating procedures were based on the Association for Perioperative Practice (AfPP) and National Institute of Health and Care Excellence (NICE) guidelines.

- World Health Organisation (WHO) surgical checklists were adapted from the national patient safety alert. There was an ophthalmology cataract specific WHO checklist.
- Specialist nurses were allocated and guided evidence based practice to provide the expertise in the department. They attended training and development to reflect the needs of the specialist consultants.
- Patients were reviewed on their sepsis management using best practice and evidence based guidance.
- Surgical site infection bundle was followed to include antibiotic prophylaxis, patient warming, hair removal and glycaemic control.
- Audits were streamlined to complete seven main topics following best practice and clinical and professional guidelines. These were completed monthly and then updated to a central system and then fed back down as a dash board. Managers told us this was helpful to identify results and trends. Issues could be picked up directly with the team at the team meeting or via staff updates.

Pain relief

- Pain relief was effectively managed. We observed staff asking if patients were in pain and issuing pain relief if appropriate. Patients told us that their pain was well managed and pain relief was given promptly if requested.
- The National Early Warning System enabled a pain assessment, records evidenced this was being completed consistently.
- Patients were encouraged to have available their own pain relief to use at home following discharge.

Nutrition and hydration

- Peoples' nutrition and hydration needs were assessed and met. The malnutrition universal screening tool was completed for each patient on admission. This screening process enables adults who are malnourished, at risk of malnutrition or obese to be identified.
- Patients were nil by mouth prior to surgery. Anaesthetist would inform the ward about fluids for patients. During our inspection the theatre list was delayed, the ward received a call from theatres to ask them to give the patients a drink. Sips of water were encouraged in recovery and on return to the ward.
- Nausea and vomiting was effectively managed for patients. Anti-sickness medication was administered to patients as required.
- Patients were provided, dependent on their procedure, with tea and toast or biscuits. Sandwiches, cheese and biscuits were also available.

Patient outcomes

- There were 105 cases requiring an inpatient stay between 1 January and 31 May 2017, these were extended time in the department or overnight stays at Royal Cornwall Hospital or on the medical ward at West Cornwall Hospital. For these cases there was an average length of stay of 0.21 days.
- There were no emergency readmissions between 1 January and 31 May 2017.
- Data showed for surgical cases there were no cases of deep vein thrombosis or pulmonary embolism at West Cornwall Hospital between 1 January and 31 May 2017.
- Patient reported outcome measures from April 2015 to March 2016 (published in February 2017) considers the change in patients' self-reported health status for groin hernia procedure. Data showed the trust adjusted average health gain for a groin hernia was better than the England average.

Competent staff

- Theatre and ward staff were supported and managed. Staff received annual appraisals with their line manager. Records evidenced appraisals were completed. One member of staff's appraisal had expired, however was booked in. Managers told us the process for appraisals linked to objectives and was a simple form to complete.
- There was no set programme for clinical supervision. However, staff told us they regularly received support from colleagues and managers if they requested training or support or if a training need had been identified. Clinical supervision is an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice and is part of continued professional development. It helps to ensure better and improving nursing practice.
- New staff underwent a corporate induction and local induction procedure to ensure staff were effectively and appropriately introduced to the trust's culture, environment and ways of working. New staff we spoke with said they felt this induction had prepared them well

for the role, and they had been supported by all staff members. New staff in the nursing team would work supernumerary, therefore shadowing staff, until they had all their competencies signed off.

- Staff said they were supported to complete training to improve their skills and were able to access courses relevant to their role. For example one ward nurse attended training to include cannulation, venepuncture and intravenous medication. Theatre staff training was done in conjunction with St Michaels Hospital theatre team. Management said additional funding for training can be difficult, however they were linking with other trusts to share training and skill building.

Multidisciplinary working

- Staff within the surgical service worked together to assess, plan and deliver people's care and treatment. It was evident through observation, and confirmed by staff, that theatre and surgical unit staff had a good rapport and working relationship.
- One locum consultant anaesthetist spoke very highly of the operating department practitioners who assisted them, and how there was good relationships between the theatres and ward.

Seven-day services

- The pharmacy department was on site at West Cornwall Hospital, they were available 8am to 5pm Monday to Friday. Outside of these hours the pharmacy team at Royal Cornwall Hospital could be contacted.

Access to information

- Staff had all the information they needed to deliver effective care and treatment to people who use services. Patient records were available on admission, this ensured medical and nursing staff had access to patient medical information. Ward clerks told us records were mostly available for theatre lists, these were requested approximately 10 days in advance. There was an emergency line to request records for patients added late to the theatre list.
- Clear and appropriate information was included on discharge summaries. These were initially completed by the consultant with final completion at discharge by nursing staff. Discharge summaries were given to the patient and immediately sent to the GP. We reviewed four completed discharge summaries, information included; diagnosis, treatment undertaken, further follow up or needs, medication to include changes and the wound.
- Information could be sent to district nursing teams in the community, the ward nursing staff confirmed they will phone district nurses to inform of dressing changes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- People's consent to care and treatment was always sought in line with legislation and guidance. Consent was obtained from patients via written consent forms and verbally. Pre-operatively medical and nursing staff spoke to the patient about their procedure and confirmed their consent.
- Staff had good knowledge of their roles and responsibilities surrounding gaining consent and assessing for mental capacity. Mental Capacity Act and deprivation of liberty training was fully incorporated into mandatory training.
- All consent forms checked for patients in theatre were completed, signed and dated by both the patient and consultant. We observed a patient confirming the consent detail with the anaesthetist.
- We observed staff asking patients for verbal consent throughout care and treatment.

Are surgery services caring?

Good

We rated caring as good because:

- Feedback from patients was consistently positive about the care and treatment they had received.
- We observed staff always treating people with kindness, dignity, respect, and compassion.
- Staff kept patients informed about their care and treatment and ensured their understanding.
- Staff recognised when people needed additional support and provided reassurance to patients.

Compassionate care

- Feedback from people who use the service was continually positive. There were positive results from the friends and family test. For the month of June 2017,

the ward reported a friends and family test result of 98% based on 35 patient responses. Staff told us they used the friends and family test to learn and improve the care they were delivering.

- There were 189 positive comments from the friends and family test recorded between January and May 2017. Comments included; "friendly, kind staff, informative and explanations good. Calm ambience.", "friendly and comforting staff", "very efficient unit, excellent staff and care" and "amazing staff, treated brilliantly".
- During the inspection we observed patients being consistently treated with compassion and kindness. Good relationships were built between the staff and the patient. One healthcare assistant added a sense of humour appropriately when interacting with patients to keep them at ease.
- We spoke with six patients and two relatives, all were positive about the care and treatment they had received. Comments included; "care was very good….the staff were polite and calm…staff made me feel comfortable", "wonderful care….staff had a sense of humour which made the whole visit a lot easier and better".
- Patients we spoke with told us they were always treated with dignity and respect.
- Staff on the surgical unit recognised the importance of maintaining patient privacy, dignity, and respect. We observed curtains being drawn when care or confidential discussions were taking place. When patients arrived at the unit they provided their details to the ward clerk, should another patient arrive at the same time they were asked to wait in a waiting area to ensure patient confidentiality for the patient talking to the ward clerk.
- Staff exhibited dignity, respect, kindness, empathy and privacy at all times in theatre and recovery. Patients were reassured and questioned about their comfort on a regular basis.
- We observed staff responding quickly to patient call bells. When patients were brought to the ward from recovery they were given the call bell and informed to ring if they required staff help.
- We observed a nurse collecting a patient from recovery, the nurse checked how the patient was feeling and got them a blanket as they were cold.
- The ward displayed their monthly C.A.R.E audit results. The C.A.R.E campaign looks at whether staff, **C** – communicate with compassion, **A** – assist with toileting, ensuring dignity, **R** – relieve pain effectively and **E** – encourage adequate nutrition. For June 2017 the ward had achieved 100% in C, A, E and 97% in R.
- There were a large number of thank you cards received which were displayed on the surgical unit. All cards we looked at were complimentary about the staff and care received. Comments included, "you were all professional, caring and empathetic", "the standard of care I have received has been second to none, in fact the best care I have encountered" and "I really appreciate your kindnesses."

Understanding and involvement of patients and those close to them

- Patients felt involved in their treatment and care. We observed staff explaining things to patients and ensuring they were given the opportunity to ask any questions. All patients we spoke with said they understood their treatment and had reported they had been given sufficient information. One patient we spoke with commented, "I am always given the time to ask questions by all staff", another patient said "staff explained things well and it was easy to understand".
- Relatives were encouraged to be involved in discussions and care where appropriate. Relatives we spoke with reported they were also given the opportunity to ask questions and were kept updated.
- We observed a health care assistant maintain good communication with the patient, keeping them engaged and informed. They explained what they were doing and the reasons why.
- Family and friends were encouraged to support the patients, once on the surgical unit following patient surgery staff would contact families or friends and they were able to remain on the unit with the patient.
- The consultant surgeon visited patients ahead of their operation, they were clear and ensured patient understanding. They clearly discussed the plan for the patient and procedure, what was happening, the risks of the procedure and information for discharge. The consultant always provided the patients with the opportunity to ask any questions.
- At discharge patients were provided with an information leaflet, we observed the nurse explaining this leaflet in detail to the patient.

Emotional support

- Staff were aware of the emotional impact treatment could have on a patient's wellbeing and recognised when patients needed additional support. One comment in a thank you card the ward had received included, "I came in a little up tight but within a few minutes in the ward everyone made me feel relaxed and comfortable".
- When patients and relatives were asked if staff provided them with emotional support one patient told us how staff were very approachable, another patient said "staff were very reassuring and able to give great emotional support, especially as this was my first general anaesthetic and I was nervous about that".
- During an admission assessment the assistant practitioner ensured they checked how the patient was feeling and provided them with reassurance. They also gave them the opportunity to ask any questions.

Are surgery services responsive?

Good

We rated responsive as good because:

- People's care and treatment at West Cornwall Hospital was received in a timely way. Admissions were staggered and theatre lists were rarely delayed.
- Staff considered people's individual needs and were able to adapt to ensure people were comfortable and supported when receiving care and treatment.
- Staff could demonstrate how changes were made to their practice to improve the quality of care following patient or public complaints.

However:

- West Cornwall Hospital theatres were not being used to full capacity.
- During our inspection one theatre list was cancelled due to a consultant no longer being available. This meant one theatre was not being utilised. However, there was no capacity for consultants to run additional lists.
- The target for less than five theatre cancellations a week was regularly not being achieved.

Service planning and delivery to meet the needs of local people

- The service was planned and delivered to see only elective day case patients in line with admission criteria. The services delivered were dependent on which consultant was booked for the day and the type of patient list the consultant treated.
- There was a treatment centre on site at West Cornwall Hospital, the treatment centre carried out day case surgery for example dermatology, ambulatory gynaecological procedures and ophthalmology.
- The hospital had recently started to see patients who had a body mass index of 40 or below, where as previously the criteria had been 35 and below. This was assessed during pre-operative assessments. West Cornwall Hospital had access to a bariatric bed and each theatre trolley could take up to 35 stone.

Access and flow

- Between April 2016 and March 2017 the trust's referral to treatment time (RTT), percentage of patients seen within 18 weeks, for admitted pathways for surgical services was consistently better than the England overall performance. Trust wide ophthalmology was at 85% compared to 77% England average, urology was 79% compared to 78% England average and oral surgery was 86% compared to 68% England average. General surgery was below the England average at 55% seen within 18 weeks compared to 75% England average.
- Theatre lists regularly ran Monday to Friday, with additional Saturday lists. On the day of our inspection only one theatre was operating, the second theatre list had been cancelled due to the consultant not being available. We were informed of this cancellation two weeks prior to our inspection. The trust were unable to book an additional list due to consultant capacity. Staff told us this was a rare occurrence for a whole theatre to not be operating.
- Patients were admitted to the surgical unit, here patients were reviewed and consented prior to preparation for surgery. Admissions were typically staggered with a morning and afternoon admission, this ensured patients were not kept waiting on the unit for longer periods than necessary.
- Patients would undergo their procedure in theatre and recover in the recovery unit before returning to the surgical unit in single sex bays before discharge. Discharge timings were typically dependent on the procedure undertaken and therefore the list orders were considered in line with typical discharge times. For

example a laparoscopic cholecystectomy patient would be discharged three to four hours following procedure, and a hernia patient would be discharged approximately two hours following procedure. Patients would be kept longer if required, for example if their pain was not under control or there had been no urine output.

- There were very few problems with patient throughput as only two operating lists ran at the same time. Staff told us delays to lists were rare as lists were known in advance so theatres were prepared with staff and equipment and there were no restrictions on bed availability.
- Theatre utilisation, timings and turnaround times were monitored and reviewed monthly. We reviewed data for June 2017 against a 100% target whereby theatre utilisation was at 82%. Theatre utilisation could be captured and reviewed by each consultant to identify any low performing consultants. Data also showed 60% of sessions started on time and 93% finished on time or earlier. Turnaround between patient in recovery and next anaesthetic start achieving 10 minutes was at 78%.
- Monthly theatre utilisation data provided to us for the time period December 2016 to May 2017 for each of the two theatres ranged between 63% and 75%, on average the utilisation for theatres at West Cornwall Hospital was 68.4%. This indicates theatres were not being used to their full capacity. However, data is negatively skewed (shows the figure to be lower than it actually is) because the theatres are not being used at weekends. But it evidences how theatres are available and not being used to full capacity to support the wider trust.
- A key performance indicator (KPI) tracker was maintained for West Cornwall Hospital. This reviewed activity against KPIs, to include available sessions versus actual sessions and cancellations. These were RAG rated (Red, Amber and Green) to assess the hospital performance.
- Cancellations were not achieving the hospital target. There was a target for West Cornwall Hospital to have less than five cancellations a week. On average they were experiencing seven cancellations a week with some higher weeks due to equipment failure. Cancellations were typically due to patients being found to be unfit for surgery and could be aligned to a poor pre-assessment. Clinical directors were reviewing each cancellation on the day, particularly those resulting from a clinical decision.
- The trust gastrointestinal surgery on call rota had been redesigned to ensure the emergency service was safe. This has had a knock on effect on elective lists at West Cornwall Hospital causing cancellations.
- Managers told us lists being cancelled at short notice can be a problem for staff as there is less work and it is unproductive. The high number of cancellations on the day were regularly due to anxious patients who do not attend for their dental procedures. This is a national issue, however clinical directors and consultants were in the process of reviewing this at the time of our inspection. The trust were working to improve attendance and reduce last minute cancellations which impacts on productivity and utilisation of theatres. Data confirmed a trend with oral surgery patients not attending, however there was also non-attendance of patients from other surgical specialities.

Meeting people's individual needs

- The needs of different people, including those in vulnerable circumstances, were assessed pre-operatively. This enabled plans to be put in place ahead of the patient admission. This was checked further on admission, for example a patient's cognition/ capacity, communication and mobility was assessed.
- There were arrangements in place for people who needed translation services. Staff confirmed this was arranged prior to the patient's admission, in the rare occasion this was not pre-arranged the translation service could be contacted. Staff said the translator was able to support the patient through the whole pathway, attending in the anaesthetic room and in recovery.
- Patients living with dementia were not regularly patients for surgery at West Cornwall Hospital. However staff were aware of processes to follow. Staff received online dementia training. Relatives were encouraged to support the patients throughout their pathway.
- Mental health concerns were generally picked up during pre-admission, however staff were able to refer to the trust's mental health team if they had any concerns.
- Systems were in place to ensure patients who may need additional help were supported. Staff had access to a psychiatric liaison nurse who would notify the department if a patient with additional needs was attending and would either provide help and advice either the phone, or attend the appointment.
- Staff felt they could identify if patients required additional psychological support and were able to sign

post them as relevant. However, it had been identified that there was no psychological support for patients undergoing dental procedures which was resulting in high cancellations of patients with a phobia. This was being reviewed by the trust by comparing processes with other trusts to see how this support can be provided to patients both for their benefit and for utilisation of theatres.
- There were facilities available for patients to give them time away from their bed space. The surgical ward was separated in to both a male and female bay with each having access to a separate day room. Each day room contained a television and a selection of books.
- Information leaflets were clearly displayed on the ward and provided information to patients on a range of subjects, including post-surgical care and signs and help if dealing with discrimination.

Learning from complaints and concerns

- The service received very few concerns or complaints from members of the public and patients. Staff were able to tell us about the action they would take if a patient did complain. This included trying to deal with things locally and then directing patients to the patient advice liaison service if it could not be resolved.
- Staff explained how they had learnt from one complaint. One patient complained about their experience of treatment, which impacted them due to their disability, as a result staff have learnt and have changed their practice if people with this disability undergo the procedure.
- Information was not clearly displayed to inform patients of how to make a complaint or how to access the patient advice liaison service.

Are surgery services well-led?

Good

We rated well-led as good because:

- Staff were positive about the current local leadership, however there was expected change when the new ward manager and theatre manager start in post in August 2017.
- Staff worked as part of a team and were proud of the high quality care they were able to deliver.
- There was a clear vision for the surgical services at West Cornwall Hospital, but the direction for this was dependent on the review of the infrastructure.
- There was a clear governance route for information to be cascaded up and down. Speciality governance newsletters kept staff informed of current risks and learning from incidents, complaints and mortality.

However:

- We were not provided with the assurance that risks were being identified, managed and recorded effectively.
- Public engagement was limited to the friends and family test.
- There were limited ways to engage staff and actively seek their feedback, however staff were happy to raise concerns and feedback through their management structure.

Leadership of service

- Staff were complimentary about their current local leadership to include the acting ward manager and acting theatre manager. It was mentioned how the surgical clinical matrons were approachable, however had limited time at West Cornwall Hospital.
- The acting ward manager and acting theatre manager would be in post until August 2017 until the new managers are in post. They provided the on-site leadership for the surgical service. Additionally on site was a hospital manager and one non-surgical clinical matron, the clinical matron acted as the on-site link for the surgical clinical matrons.
- On-site managers told us there was good support from senior staff both directly above and at divisional director level. Communication was received face to face, email updates and meeting minutes. They felt peer to peer support was good between the three sites.
- Staff had not met the Chief Executive and struggled to recall their name.

Culture within the service

- There was a positive culture. Staff were proud of their work and their colleagues, they felt they had the time to provide high quality patient care and keep patients at the centre of the service they are providing. They were happy in their working environment which enabled a positive atmosphere and good team spirit.

- Staff spoke of a supportive environment, where leaders at all levels were approachable. Staff felt confident in raising concerns and that their concerns would be listened to.
- Managers felt the culture was open, honest and hardworking. Staff would challenge and speak up where required.

Vision and strategy for this service

- There was a trust vision and values, staff were aware of these and they were displayed at West Cornwall Hospital.
- The vision at West Cornwall Hospital was to increase the use of theatres and provision of surgery by moving to a 23 hour service which would mean an overnight stay for patients. Staff were aware on this vision and felt there was a clear direction. Clinical directors were in the process of reviewing specialities and suitability for lists at West Cornwall Hospital. Consideration was being given to staffing, particularly medical staffing, cost and the risk of medical outliers on the surgical unit to ensure the sustainability of a 23 hour service.
- The clinical director for West Cornwall Hospital was part of the sustainable transformation project working group and therefore ensured the perspective of West Cornwall Hospital was heard and integrated into the planning. This however was not specific to surgery.

Governance, risk management and quality measurement

- Leaders and staff were clear of their roles and responsibilities within the governance framework, however we were not assured risks were being effectively managed.
- Governance meetings were held monthly for each speciality (directorate) and fed in to the surgical service divisional board. Speciality governance newsletters were disseminated to staff and included information on; speciality related incidents, surgical directorate never events and serious incidents, risks, mortality, complaints and national safety standards for invasive procedures.
- The surgical services divisional board then reported to the trust management group which in turn reported to the trust board.
- Additionally weekly surgical operational meetings were held.
- A key performance indicator tracker was used to review the quality measures, this included capacity, utilisation, cancellations, length of stay and readmissions.
- Staff said information was cascaded down to them through the management structure.
- There were occasional ward meetings, however staff said managers had an open door policy and kept staff well informed as they were only a small workforce.
- The theatre team held a daily huddle, which was also attended by the ward managed. This enabled staff to be updated of any relevant information, discussion the day activities and address any problems.
- Managers told us governance outcome information was reviewed centrally and presented back to give a good oversight.
- There were not robust arrangements for identifying, recording and managing risks, issues and mitigating actions. We were told risk registers were held for the hospital and escalated to the divisional and corporate risk register as required. However, on request of the risk registers for theatres and the surgical unit at West Cornwall Hospital we were only provided with one risk register containing two risks for theatres.

Public engagement

- Patient's views were gathered to develop services, however this was limited to friends and family tests. Friends and family tests were clearly displayed in the ward as well as being left in each bed space. Changes had been made following patient feedback. The female and male bays were due to be renamed following a patient raising concern about why she was being placed on a 'male ward', when on the day she was being treated the male ward was being used for females only. However, there was little other ways in which patient opinion was obtained.

Staff engagement

- There was not a specific forum for staff to engage and provide feedback. However, staff said they were confident to raise any concerns or feedback via their management structure.

Innovation, improvement and sustainability

- The Surgery Productivity Task and Finish Group had a number of work streams to look at the ways in which surgical services could be improved. This included; scheduling, pre-operative assessment, theatres on the

day, St Michaels Clinical Programme Board, West Cornwall Clinical Programme, and speciality specific projects. The work streams were at various stages, however were in progress with an aim to improve the delivery of the service in the future.

- The theatres on the day work stream looked at how productivity in theatres is better with a regular team and therefore staffing and lists could be arranged to ensure consistency. This poses a challenge where there is not a full complement of anaesthetists, therefore West Cornwall Hospital regularly experiences locum anaesthetists.
- The pre-operative assessment work stream has rolled out across specialities over the previous two years the electronic add to waiting list. This enables, at decision to operate, for information to be instantly available to booking teams for pre-operative assessment. Other improvements have been the ability to access GP information to ensure full information is provided. The clinical triage process has been reviewed on whether patients require a telephone call with the nurses, a face to face appointment with the nurse or a face to face appointment with the anaesthetist. Through this process the trust have found the number of patients turning up for surgery and being found to not being suitable for West Cornwall Hospital has dropped significantly. The work stream is also exploring ways to improve the paper based pre-operative assessment and to move this to an electronic assessment process, enabling nursing assessments to be prefilled from the electronic patient questionnaire and be available for subsequent assessments throughout the patient pathway.
- The West Cornwall Clinical Programme was yet to be developed in to a board arrangement similar to St Michaels Clinical Programme. The programme reviews the surgical activity at West Cornwall Hospital. It had raised awareness to senior management of the low session utilisation and under booking of lists. The decision has been made for two clinical directors to take responsibility for the site to ensure leadership is in place and to drive improvements. The strategy was being formed at the time of our inspection with regards to which specialities and lists would be suitable for surgery at West Cornwall Hospital. We were told from this a working group can be set up and staff can be involved in the strategy.
- The scheduling work stream was looking at developing standard operating procedures for booking to ensure appropriate patients were booked. This would reduce the cancellations for patients who are not appropriate for West Cornwall Hospital. They were also reviewing how to manage lists with whole day lists, job plans and aligning to theatre. Each speciality was being reviewed against the British association of day case recommendations. Cancellations on the day were being reviewed, particularly for dental surgery where there were high numbers of patients not attending. The clinical director and speciality lead had accepted a case for change, but it was early days to see the improvements in dental surgery cancellations.

Outpatients and diagnostic imaging

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

Information about the service

West Cornwall Hospital in Penzance is a registered location of Royal Cornwall Hospitals NHS Trust. It provides a range of outpatient and diagnostic services.

We visited the service for one day and spent time in the general outpatient's area, diagnostics department and the treatment centre.

There is one main outpatient department within West Cornwall Hospital, accommodating a number of services. The Treatment Centre also holds outpatient appointments, which may include minor surgery. Between July 2016 and June 2017 there were 42,884 outpatient appointments at West Cornwall Hospital.

West Cornwall Hospital has a diagnostics department providing general X-ray services, computed tomography (CT) scans and ultra sound scans services. The department is open on Monday to Friday between the hours of 9am and 5pm and out of hours cover for the urgent care unit and patients referred by their GP. Between July 2016 and June 2017 there were 25,060 diagnostic procedures carried out at West Cornwall Hospital.

There is a central outpatient booking team which supports the majority of specialties.

Outpatient services were last inspected in January 2014 when safe, caring, responsive and well led domains were all rated as good. We do not hold sufficient evidence to rate the effective domain.

Summary of findings

We rated this service as good because:

- People were protected from abuse and avoidable harm.
- People were supported, treated with dignity and respect and involved as partners in their care.
- Care and treatment was delivered in line with evidence based best practice guidance.
- Staff were competent in their roles and attended training regularly.
- People's needs were met by well organised and well managed services.
- We saw and heard about person centred care.
- There was a positive, open and fair culture.

However:

- Fabric curtains as opposed to disposable curtains were used in the diagnostic imaging departments, which could pose an infection control risk.
- There were two cardiology clinics timetabled each month at West Cornwall Hospital which were very rarely utilised due to a lack of cardiologists available to run the clinic.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- Staff reported incidents and demonstrated knowledge of how to do this.
- The premises we visited were visibly clean and tidy. Staff adhered to infection control policies and procedures.
- Equipment was in working order and had been serviced/calibrated as required. Resuscitation equipment was checked regularly.
- Medicines and prescription pads, where in use, were stored and managed appropriately.
- Patients' individual care records were stored securely in the outpatients and diagnostic imaging services.
- There were arrangements in place to safeguard adults and children from abuse, which reflected relevant legislation and local requirements.
- Staff were 100% complaint with their mandatory training.
- Staff received training to look after people in an emergency.

However:

- Fabric curtains, as opposed to disposable curtains, were in use the in the diagnostic imaging departments, which may pose an infection control risk.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and externally. Staff reported incidents on the electronic reporting system and demonstrated knowledge of how to do this. Clinical staff told us, in the past, they had reported poor cleanliness in their clinical areas as an incident so that it was logged in the right place. The level of cleanliness had improved as a result.
- The outpatient department manager gave us examples of issues they and their team had reported as incidents. These included when patient transport had not collected patients up to two hours after their appointments. This meant two staff had to stay after the unit had closed. Staff offered the patients a drink or a snack and contacted relatives or care agencies to say the person would be late. During the extended wait, staff reported they were not able to provide pressure area care to the patient apart from perhaps encouraging them to stand at times. This sometimes gave rise to concerns for the patient's health and wellbeing. The incident was recorded on the electronic incident reporting system and a call was also made to the manager of the trust's transport team for them to follow up with the patient transport provider. However, staff told us these delays continued to be an issue.
- The outpatient department manager said that if an incident report related to a member of staff's personal safety, the trust's personal safety trainers were informed. They usually called the department the following day to provide support and talk through the incident. They made a visit to assess the environment if necessary.
- When things went wrong in the outpatients and diagnostics department, reviews or investigations were carried out. Serious Incidents were investigated. There were no serious incidents reported in the 12 months prior to the inspection.
- There had been no never events in the outpatients or X-ray departments in the twelve months prior to our inspection. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Most radiographers said they got feedback on any incident reports they had made. Feedback and lessons learnt from reported incidents were fed back at monthly team meetings, which were minuted. The minutes were made available so staff who were unable to attend the meetings could see what was discussed.
- The imaging service ensured if necessary, that exposure that was 'much greater than intended' was notified. This was either to the Care Quality Commission under IR(ME)R regulations or to the Health and Safety Executive (HSE) under the ionising radiations regulations (IRR99) requirements.

Duty of Candour

- 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.
- Staff were able to describe what the duty of candour meant, the actions they needed to take and how to access the trust guidance on the process. Staff said they received guidance on the duty of candour during their mandatory training.

Cleanliness, infection control and hygiene

- All areas we visited (reception, main outpatients, diagnostic imaging and the treatment centre) appeared visibly clean and hygienic and were free of clutter.
- We saw staff adhered to the trust's 'bare below the elbow' policy. There were hand-washing sinks available in all departments and consulting rooms. At each sink, liquid soap, paper towels and pedal bins were provided, in line with good infection control practice. Hand hygiene compliance audit results for the main outpatient department for June 2017 were 100%. The results were displayed in patient areas.
- Personal protective equipment (disposable gloves and aprons) was readily available in all departments and we saw staff using them appropriately.
- In the diagnostic imaging department we saw staff using good hand hygiene techniques. Staff were using appropriate cannulation (a technique in which a cannula is placed inside a vein to provide venous access) and associated aseptic techniques (a set of specific practices and procedures performed under carefully controlled conditions with the goal of minimising contamination by bacteria).
- In the main outpatient department, consulting rooms were cleaned following each clinic. 'I am clean' stickers were placed on equipment with the date and name of person who had cleaned it recorded. We saw stickers in place in a number of rooms we looked in.
- There were good cleaning procedures and equipment was easy to maintain. Cleaning wipes were readily available in clinic rooms to clean weighing scales and consulting couches after each use. Toys in the waiting areas were made of materials that were easily cleaned. All toys were washed weekly. We saw the audit kept to show the cleaning had taken place. Chairs in all the waiting areas we saw were in a good condition and had wipe-clean surfaces.
- We saw daily cleaning schedules for the departments, except for the X-ray department. They were detailed and signed once the task had been completed. The X-ray department however, did look visibly clean, but no schedule was available to check
- There were fabric curtains, as opposed to disposable curtains, in use in the diagnostic imaging department. Although the curtains appeared visibly clean there was no assurance that they were regularly cleaned and therefore they could pose and infection control risk.
- Clinical staff told us the housekeeping staff went above and beyond what is expected of them, despite staff shortages and related pressures. They felt the cleanliness of their clinical areas had improved recently, with better housekeeping staff numbers. Department managers met with the external cleaning provider regularly to assess their particular areas.

Environment and equipment

- There were safety systems to warn people about entering rooms when tests were underway. A red light came on when diagnostic machines were being used to ensure people did not enter the rooms. Lead coats were available for staff and carers who may need to support a patient during an X-ray. These were visually checked each day for damage and were stored correctly.
- The department had emergency equipment and call bells. There was access to resuscitation trolleys in the main outpatients department, the treatment centre and diagnostic imaging. They had been checked daily to ensure all the required equipment was in place and not been tampered with. The daily checks were documented. There were emergency call bells in the consulting rooms and toilets so that people could summon assistance if required.
- Equipment was regularly maintained, calibrated and serviced in order to keep people safe. We saw stickers on equipment to show when the next planned maintenance/servicing was due.
- There were safe systems in place for managing general and clinical waste and clinical specimens. We saw documents detailing the specimens taken, the date and when collected.

Medicines

Outpatients and diagnostic imaging

- Medicines requiring cold storage were stored safely. The medicines refrigerator temperatures were measured and the results documented daily. There was guidance for staff to follow if the temperatures fell outside of the accepted range
- Prescription pads used in the main outpatient department were stored securely in a locked cupboard in a locked room. The department was issued speciality-specific prescription pads. This meant that prescriptions would be traceable if a problem arose in the future. These were signed in when received. A record of each individual prescription issued was kept.
- Radiographers used patient group directions (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presenting for treatment). This was in relation to administering contrast medium (substances used to enhance the visibility of internal structures in X-ray-based imaging techniques, such as computed tomography (CT). They were current and approved in line with the trust's policy.
- To ensure medicines or substances were given to the right patient, we observed staff carefully check patients' identities prior to administering contrast medium.

Records

- The trust had a mix of paper and electronic records. In outpatient services, there remained a reliance on paper records. There were plans to improve the records management with the implementation of electronic records systems, but this had not yet got underway.
- A number of different systems sometimes delayed locating the right place to report a patient's complaint. There were at least three booking systems used across the outpatient departments. One was for requesting tests, storing consultant letters, and test results. The second used by the orthopaedic staff, and the third another used for ophthalmology. This sometimes led to problems when trying to investigate a complaint as it was difficult to see all systems a patient might be registered on.
- Patients' individual care records were stored securely in the outpatients areas we visited. The main reception areas used computer records to book patients in when they arrived for their appointment. For confidentiality, the computer screens used were not seen by patients or others. The paper clinic lists kept by receptionists were kept covered so they could not be seen by people.
- The first page of a patient's computerised record indicated any potential issues. This included, for example, if a patient was hard of hearing or poor sighted, was living with dementia or had a learning disability. This alerted the receptionist who then approached the patient to identify and support them with their individual needs.
- There was a reliable system for ensuring medical records were available for clinics. This system was audited regularly. On average 2.5% of patients, across the whole trust, were seen in outpatients without their full medical record being available. Records were available electronically when paper records were unavailable. Staff were aware of the system to follow if records were not available. This involved making a temporary folder and extracting available information from the electronic system.
- Records were made about X-ray's carried out. Radiography staff recorded a patient's identity, following a three point identity check, justification for the X-ray to be carried out, the dose of radiation and the operator's name prior to the image being sent for investigation.

Safeguarding

- There were arrangements to safeguard vulnerable adults and children from abuse, which reflected the relevant legislation and local requirements. All staff we spoke with told us they had received safeguarding training. We had no data to confirm this.
- The outpatient department manager said that nurses and healthcare assistants had, as required, received level two adult safeguarding and level three child safeguarding training. Administrative staff had level two in both child and adult safeguarding training.
- The booking team told us if a child missed an outpatient appointment, another would be sent. If a child missed two appointments, their non-attendance would be escalated to their GP.

Mandatory training

- All staff we spoke with told us they were up to date with their mandatory training. Staff received a training date via an email and were required to undertake pre-course reading prior to the training. A record had then to be signed to confirm when the course was completed. The outpatient department manager told us they gave staff time to do the online reading prior to the half day mandatory training day.

Outpatients and diagnostic imaging

- Data we reviewed showed as of 30 June 2017 there was 100% compliance with mandatory training.
- Radiographers, in addition to the trust's mandatory training, had speciality-specific mandatory training and updates to ensure they remained competent.

Assessing and responding to patient risk

- Staff received training in basic life support and had access to emergency resuscitation equipment.
- There was information in the diagnostics waiting areas, telling pregnant women to inform the radiographer if they were pregnant. As diagnostic imaging is sometimes necessary during pregnancy a risk assessment was completed and risks discussed with the patient.
- The trust monitored the percentage of cancelled outpatient clinics (trust-wide). Performance was as follows:
  - Cancelled within six weeks of date February 2017 - 4.7%, March 2017 - 4.8%, April 2017 – 5%, May 2017 – 3.2%
  - Cancelled over six weeks from date February 2017 – 10.2%, March 2017 – 11.6%, April 2017 – 17.4% and May 2017 – 16.2%.

The main reason for cancellations over six weeks from date was annual leave. Of those cancelled within six weeks, the top reason was annual leave, followed by sickness. The trust was also monitoring through the Outpatient Programme Group the number of patients affected by short notice cancellations for avoidable reasons as recorded on the trust's Clinic Cancellation & Additions Tool (CCAT).

- On average 2.5% of patients were seen in outpatients without their full medical record being available.
- There was good signage and information displayed in the diagnostic imaging department waiting area informing people about areas where radiation exposure took place.
- Radiography staff had access to 'local rules' in relation to use of radiation. We saw these were readily available to staff and in date. Radiography staff also had access to advice from a radiation protection advisor if required.
- If a radiographer was not able to cannulate a patient prior to their diagnostic procedure they could access support from urgent care or surgical unit staff.

Nursing and allied health professionals staffing

- There was no specific acuity and dependency tool used to determine staffing levels in the outpatient areas. Staff who worked in the general outpatients and diagnostic imaging departments told us there were enough staff on duty when clinics were running. They said it was sometimes a challenge but the flexibility in the staff groups meant they were able to cover for sickness and annual leave.
- Staff occasionally had to work at the acute hospital site in Truro. They added this was not a regular occurrence and did not impact significantly on their own work at West Cornwall Hospital due to the flexibility of the staff groups.
- Staff reported a very low turnover of staff in the outpatient departments.

Medical staffing

- Medical staff attended the unit when required to carry out clinics and see patients. Outpatient clinics were staffed by consultants whose main base was the Royal Cornwall Hospital. Cover for their clinics, when on annual leave, was arranged by their medical secretaries. Staff said very rarely a clinic was cancelled due to sickness when no cover could be found.

Major incident awareness and training

- There was a trust-wide and site-specific major incident plan available that detailed arrangements to respond to emergencies and major incidents.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate the effectiveness of the outpatients and diagnostics service.

- The outpatient and diagnostic imaging services delivered care and treatment based on relevant evidence-based best practice guidance and standards.
- The outpatient and diagnostic imaging services participated in local and national audits, benchmarking and peer review.
- All outpatient and diagnostic staff were competent to carry out their roles. Learning needs were identified during their annual appraisal and the trust encouraged and supported staff with continued professional development.

Outpatients and diagnostic imaging

- All staff we spoke with reported good multidisciplinary working between different departments and other Royal Cornwall Hospital Trust hospital sites.
- Staff in all outpatient and diagnostic services were able to find and use relevant information to ensure they provided the appropriate care and support to patients.

Evidence-based care and treatment

- The outpatient and X-ray services used relevant evidence based best practice guidance and standards to develop how services, care and treatment were delivered.
- Staff showed us they had access to the trust-wide policies and procedures via the intranet. We saw relevant policies displayed in treatment rooms and staff offices.
- Local rules were available on the electronic governance system in radiology. These were the procedures for running the service in accordance with recognised practice and to restrict exposure in radiation areas. There was a paper copy in the X-ray department. These were in date. Staff were able to locate and explain how they used these as a tool. These rules were updated every two years.
- The outpatients' service used National Institute for Health and Care Excellence (NICE) guidelines. For example 66/87, which was around management of type 2 diabetes, to identify and implement best practice.

Pain relief

- Staff assessed patients' pain using informal methods during assessments or consultations. This meant pain was assessed on an individual basis and staff recorded their observations and actions in the patient records.
- There was a pharmacy on site. If a patient was given a prescription for pain medication during an outpatient consultation they could have it dispensed on site.

Patient outcomes

- The outpatient and diagnostic imaging departments participated in local and national audits, benchmarking and peer review. The Care Quality Commission outpatient survey published in 2012 found the trust overall was about the same when compared to other trusts, on all of the questions about patient's experiences when receiving care and treatment.
- There was no patient reported outcome measures' data collected for the outpatients and diagnostics service. However, several audits had been completed in the outpatients and diagnostic imaging services. This included radiation dose audits, documentation, and hand hygiene audits. Action was taken as a result of any identified areas for learning from audits, for example, discussion about good handwashing techniques.
- Radiography staff had an awareness of the Imaging Services Accreditation Scheme (ISAS). The Royal College of Radiologists and College of Radiographers have developed ISAS to support diagnostic imaging services to manage the quality of their services and make continuous improvements. The trust had applied to be accredited. The accreditation would also cover West Cornwall hospital diagnostic services.

Competent staff

- There was a range of competency programmes depending on the role of the staff. There was a competency programme in place for radiographers, which was reviewed annually at the staff member's personal development review (PDR).There was a computerised tomography (CT) training pack and competency programme for radiography staff who were training to operate the CT scanner. Staff in the general outpatient team said they had access to role-specific training if required.
- The learning needs of staff were identified using the appraisal system. All staff told us they were up to date with their appraisals. Data showed that 100% of annual appraisals had been completed.
- Nursing staff received support and advice about their revalidation with the nursing and Midwifery Council.
- The main outpatient department had first and second year student nurses on placement. Feedback had been positive, with student nurses learning about particular conditions and learning basic skills. This had included, for example, taking blood pressure and testing urine. Being in the department had improved their confidence in communication skills with patients and medical staff.

Multidisciplinary working

- All staff we spoke with reported good multidisciplinary working between different departments and other Royal Cornwall Hospital Trust (RCHT) hospital sites
- Radiography staff rotated between X-ray departments every three months. This provided continued professional development and multidisciplinary working with other colleagues.

Outpatients and diagnostic imaging

- Staff in the main outpatient department described good access to specialist teams, for example infection control services based at Royal Cornwall Hospital, and the dementia nurse based on the medical wards at West Cornwall Hospital. They told us they had good working relationships with the 80 visiting consultants who used the department.
- The community outpatient dietetics team worked at all RCHT sites, but were flexible to meet the needs of the patients. They described good working relationships with all staff groups.

Seven-day services

- The outpatient services at West Cornwall hospital ran Monday to Friday between 9am and 5pm. There were no weekend or out of hours outpatient services. However the diagnostics department provided an out of hour's service, in the evenings and at weekends, to patients referred by the on-site urgent care centre or by their GP.
- The community outpatient dietetics team worked seven days a week across the county.

Access to information

- The information needed to deliver effective care and treatment was available to staff in a timely and accessible way. Staff in all outpatient services were able to access referral letters and discharge summaries via the electronic records system.
- The diagnostic imaging staff had electronic access to diagnostic results. They were able to send X-ray results to a patient's GP within eight days following their X-ray.
- Reception staff had access to patient information when the patients arrived at the reception desks and were therefore able to quickly direct them to the correct seating area for the clinic they were attending.
- Notes were obtained prior to clinics and were sent to the correct hospital in time for the clinic so clinicians had the most up to date information available to them. On average 2.5% of patients, across the trust, were seen in outpatients without their full medical record being available. This was a low figure compared to other similar services. Temporary notes were compiled if the full medical record was not available and added to the record when it was.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated understanding of gaining consent and the implications under the Mental Capacity Act 2005. This included patients subject to Deprivation of Liberty safeguards (DOLs).
- Mental Capacity Act and deprivation of liberty training was included in the annual mandatory training programme.
- Staff told us patients had the consent procedure explained to them by the consultant or specialist nurse they were seeing.
- Patients with learning disabilities or living with dementia were supported to make decisions and, if necessary, staff would ask for help or advice from the learning disability team or dementia specialists within the trust.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- Staff understood and respected patients' personal, cultural, social and religious needs.
- Staff showed a supportive attitude to patients. When patients experienced discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way.
- We saw staff did everything possible to ensure that people's privacy and dignity was respected.
- We heard staff ensuring patients understood the information they had been given during a consultation.
- Staff considered the psychological needs of patients using their services and were able to provide support and direct people to external services who may be able to provide support.
- The department had volunteers who helped people around the department and to different parts of the hospital. They spent time with patients and provided drinks to patients who were waiting for their appointments.

However:

- We did not see any information about chaperones being available displayed in the outpatient departments.

Compassionate care

Outpatients and diagnostic imaging

- We heard staff introduce themselves when meeting patients. Staff explained their roles and responsibilities as recommended in the National Institute for Health and Care Excellence (NICE) QS15 Patient experience in adult NHS services.
- Patients we spoke with told us they were treated with dignity and respect.
- We saw a receptionist from the diagnostic imaging department, who had a friendly and welcoming manner, come out from behind their desk and escorted a patient to the toilet as they were having trouble finding it.
- Staff did everything possible to ensure that people's privacy and dignity was respected within the reception areas, outpatients and diagnostics departments. This included pulling the glass screen down at a reception desk while talking with a patient over the telephone so their conversation could not be overheard by others. Also using curtains in consulting rooms when patients were getting dressed and undressed. However, in some areas of the diagnostics department, patients had to walk through an existing X-ray room to access the room they needed to use. This could sometimes compromise patient privacy.
- The department had six volunteers. We saw them helping people around the department and to different parts of the hospital. We saw them spending time with patients who were waiting, helping to relieve their anxiety. The volunteers also provided drinks to patients who were waiting for their appointments. The outpatient department manager spoke very highly of their volunteers and the positive effect they had on patients who visited the department.
- The outpatient department manager told us keeping people informed, for example if their clinic was running late, helped to reduce patient anxiety. It assured them they had not been forgotten. Staff told the receptionist about clinic delays and they wrote this on a board clearly visible to patients. We also heard them tell patients about any delay when they reported to the main reception desk.
- The manager told us patients who had been referred for an urgent appointment were often very anxious. They provided them with information about who they were seeing and asked if they would like a volunteer to sit with them whilst they waited, which helped to reduce their anxiety.
- We did not see any information about chaperones being available displayed in the outpatient departments. Staff told us there was always one available when a patient or doctor asked for one. If a member of staff acted as a chaperone they used their name stamp next to the date stamp in the notes to show they had been involved with the patient. If no notes were available their name was added to the computer records.

Understanding and involvement of patients and those close to them

- Patients felt involved in their care and treatment. We heard staff explaining what to expect when having a scan and gave them time to ask questions.
- The outpatient department manager said to avoid sensory overload, for example, for people with autism, information on display had been condensed to the most important information.

Emotional support

- Staff considered the psychological needs of patients using their services. They were able to provide support and direct people to external services which may be able to provide ongoing support. Staff alerted consultants if they felt patients needed emotional support, as they may be able to refer patients to psychology or counselling services if necessary.
- Outpatient staff worked with specialist staff within the trust as necessary, for example, the renal nurse specialist, to provide appropriate support and advice to patients.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Information about the needs of the local population was used to inform how services were planned and delivered.
- Patients' individual needs were taken into account. For example, people with learning difficulties, living with dementia, mobility problems, hearing difficulties and visual impairment may be given longer appointment times.

- The service was accessible. There was and pay and display parking, with spaces allocated to patients with a disability.
- Information sent to patients prior to their appointments and information leaflets were available in different formats, for example, large print or alternative languages. Translation services were available from a telephone service.
- Patients could be reminded via an automated telephone call a week before their appointment and by a text message two days before their appointment. Patients had an option to change their appointments at this time.

However:

- There were two cardiology clinics timetabled each month at West Cornwall Hospital which were very rarely being used due to lack of cardiologists available to run the clinic.
- The there was no data available, trust-wide, to show the proportion of patients that waited more than 30 minutes to see a clinician or what percentage of clinics started late.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. There were good facilities for people. In the main outpatients department there were toys available in waiting areas, for children who were waiting for appointments. There were toilets available for patients' use in all outpatient departments. They included toilets accessible for patients with a disability. There was a café run by volunteers open most week days and vending machines that were stocked with snacks and hot and cold drinks.
- People had good access to the hospital. The main outpatient entrance area was accessible via level access. Access from the main entrance to the hospital was via stairs or a small passenger lift. The treatment centre had level access from the hospital main entrance. There was a spacious reception area with an open reception desk that was at a low height, therefore accessible to wheelchair users.
- There was a pay and display car park with spaces allocated for people with a disability outside the main entrance to the hospital. This was close to the diagnostic imaging department, physiotherapy and the treatment centre. However, there was limited parking at the entrance to the main outpatients department. There were plans to reduce the size of the ambulance turning area to provide two more parking spaces. There was no date agreed for the completion of this work.
- The main outpatient departments were clearly signposted and there was a reception desk in the main entrance from where staff directed patients. The entrance led patients straight to a reception desk from where patients were directed to their waiting area.
- Information sent to patients prior to their appointments was available in different formats, for example, large print or alternative languages.

Access and flow

- Appointments were booked via a referral management service. The booking team received the referral, and contacted the patients to book an appointment. Consultants then reviewed the referrals and any patient who was deemed not suitable would be contacted and have their appointment cancelled. A letter sent to the patient's GP explaining the reason for the cancellation and any action or additional information required.
- Patients were reminded about their appointment through an automated telephone call a week before their appointment and by a text message two days before their appointment. Patients had an option to change their appointments at this time.
- There was a cancellation policy that stated if patients missed two appointments they were referred back to their GP. This helped make sure the service was as efficient as possible by trying to ensure appointments were not made for people who no longer needed them.
- People were being seen in good time. Between April 2016 and March 2017 the trust's referral to treatment time for non-admitted pathways had been better than the NHS overall performance. The latest figures for March 2017 showed 97% of this group of patients were treated within 18 weeks versus the NHS average of 90%. Over the last 12 months the trust had consistently performed better than the England average. Between April 2016 and March 2017, the percentage of diagnostic waiting times, across the trust, that were longer than six weeks was similar to the England average.
- The manager for the main outpatient department told us they sometimes had to run an extra clinic to meet the urgent two week referrals in time. They added that there

were two cardiology clinics timetabled each month that were not often used due to lack of cardiologists available to take the clinic. This meant the outpatient department sometimes ran at less than full capacity.
- The trust told us there was no data available, trust-wide, to show the proportion of patients that waited more than 30 minutes to see a clinician or what percentage of clinics started late.
- During our inspection we saw patients did not wait long before they were called in to see the clinician in either the general outpatient department or the X-ray department.
- There was a project underway to standardise the referral criteria for all physiotherapy departments, run by the trust, across Cornwall. This was in an effort to improve access to and flow through departments.
- Physiotherapy waiting lists were around six weeks. This was good in comparison with other units we hold data for. Any empty slots were filled by calling patients and asking if they could attend at short notice.
- There was a trauma assessment clinic held each day in response to numbers of patients attending the urgent care centre. This had proved successful and was well attended. We were told the orthopaedic fracture clinic had not been running but a plaster technician had been employed and the clinic was now up and running again.

Meeting people's individual needs

- If staff were aware that a patient was living with dementia or had a learning disability, prior to their appointment, they could extend appointment times, carers and/or family members were encouraged to accompany the patient if appropriate. There was access to the trust learning disability link nurse, based at the Royal Cornwall Hospital, if required
- Translation services were available through a telephone service. Radiographers said this was organised at the time of booking an appointment for a patient. Outpatient staff confirmed they used the translation service occasionally and it worked well for consultations.
- We saw staff helping people with mobility needs move around the departments.
- There were chairs suitable for bariatric patients in the main outpatient department and chairs of different sizes and heights in all of the waiting areas. The chairs all had arms for people to use to help them when standing. The outpatient department manager told us that staff had tested chairs in the waiting room to see how they felt for the patients.
- The main outpatient department manager was aware that patients who were, for example, on the autistic spectrum might find a busy outpatient department quite a challenge. They explained if they knew about a patient's condition prior to the appointment they would use a quieter waiting area. They would also make the appointment for the beginning or end of a clinic when the area would be quieter.
- We saw one patient who had not been checked in for their diagnostic imaging appointment and had been missed in the waiting room. As a result, their appointment was delayed and they had to pay for more parking. While the patient was disgruntled, the situation was handled well and sensitively by staff and the patient was satisfied.
- We saw one patient who attended the treatment centre when they should have been at the main outpatient department. This was some distance away, across the other side of the hospital. The appointment letter the patient received had led to the confusion. The receptionist apologised and offered the patient a wheelchair if they needed one to get to the main outpatient department. The receptionist also telephoned the main outpatient reception to let them know the patient may be late but they were on their way.

Learning from complaints and concerns

- Leaflets about how to make a complaint and/or contact the patient advice and liaison service (PALS) were available in the department.
- We were told if patients had any concerns or complaints staff would deal with them at the time, if patients made them aware. This practical approach resulted in few formal complaints, as staff were able to help people directly.
- Feedback forms and NHS Friends and Family Test questionnaires encouraged people to say if they had any concerns. The manager for the main outpatient department said they encouraged patients to complete the questionnaires and aimed for 150 completed each month. They said "if we don't get feedback we can't get any better". There was 'you said, we did' information displayed in the main outpatient department. This was

to explain to people who had taken the time to raise a concern or make a suggestion what had been done. One example that came from this was the provision of a variety of chairs to enable people of different abilities to get up from a chair.

- There had been two complaints made about clinical imaging at the hospital in the 12 months prior to the inspection. One related to an historic incorrect diagnosis. The other was in relation to a cancelled scan that the patient was not notified about, and the attitude of staff. Both were investigated using the trust's complaints procedure and neither complaint was upheld.
- There had been no complaints relating to the main outpatient department or treatment centre in the 12 months prior to the inspection.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- The local management team was well respected. They supported their teams and promoted good quality care. The departments we visited appeared well organised and were running smoothly.
- There was a very positive culture in all of the outpatient and diagnostics departments we visited.
- Staff felt informed about activity across the trust as a whole.
- Senior staff felt supported by directorate managers across the trust.
- There was a programme of audit and work streams where areas for improvement were identified and changes implemented.
- Public engagement was ongoing and the hospital had a very active League of Friends. A Community Forum , facilitated by the hospital, run by the general public met bi-monthly

Leadership of service

- Staff were complimentary about their local line managers and the hospital manager. They said they felt informed about what was happening trust-wide and at West Cornwall Hospital. They felt regularly informed about risks, performance and required changes to practice.
- The clinical matron and department managers carried out a weekly walk round of their departments to look at the environment and assure themselves the departments were running as they should.
- Local managers told us there was good support from senior staff, both from those based at West Cornwall Hospital and at trust-wide divisional level. Communication was face-to-face, via email updates, telephone and minutes of meetings. They felt peer to peer support was good between the three hospital sites.
- Staff had met the trust Chief Executive who had visited the hospital two days following their appointment. They said senior management team members also visited the site regularly. Staff told us they had seen members of the trust's senior management team at the hospital at times.

Culture within the service

- There was a positive culture in all the departments we visited. Staff at all levels were friendly and interacted well with each other. Staff spoke of good teamwork and flexibility within the staff groups.
- Staff felt their local managers listened to them and would take action if they raised concerns or issues with them. They described them as approachable.
- Local managers felt staff were able to challenge decisions and speak openly when required.
- Radiographers had reported incident reports in relation to lone working in the evenings when they provided cover for the urgent care centre. The hospital manager explained the action they had taken to mitigate the risk to staff. This included locking the front entrance of the hospital at 8:30pm so patients had to access services via the urgent care centre. Also, patients who were assessed as posing a risk to staff were escorted to X-ray by urgent care staff, who stayed during the procedure, ensuring a radiographer was not left alone with the patient.
- Patients' records were transported to the main outpatient department in wheeled cages. However, the notes, some of which were heavy, had to be removed from the cages and placed on shelves in the administration office to be distributed to the correct

clinic. This had been noted as a manual handling risk by the outpatient manager, who was working, along with the staff, on solutions to reduce the need to move notes around.

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- The security manager for the trust had been helpful in putting together a management plan for a patient who came to the hospital on occasion and presented with unacceptable behaviour.

Vision and strategy for this service

- Staff were aware of the trust's visions and values and they were displayed at West Cornwall Hospital.
- The local sustainability and transformation plan (to help ensure health and social care services locally are built around the needs of the local population) was being taken into consideration when planning the service going forward.

Governance, risk management and quality measurement

- Local managers were clear about their risks and how these were managed. Risk registers were held for the hospital and escalated to the divisional and corporate risk registers as required. The outpatient department manager said the West Cornwall Hospital risk register was available to all staff via the trust's shared drive. The risk register was reviewed at the monthly governance meeting and actions updated.
- Radiography staff said they received feedback about any governance issues at their monthly audit meeting. Radiographers said they were encouraged to be involved in the audit process.
- There was a monthly governance meeting held at West Cornwall Hospital. Somebody from each department attended. This meant staff shared ideas, issues and pressures in different departments.

Public engagement

- The local population enjoy having the hospital in their town and had, over the years, attended meetings and events in support of the hospital.
- Patients' views about the general outpatient department were gathered via the NHS Friends and Family Test questionnaire. Results were displayed in the department.
- There was an active League of Friends who had helped to pay for equipment and environmental upgrades over the years.
- A Community Forum run by the general public met bi-monthly. People who attended included hospital staff, members of the hospital's League of Friends, Healthwatch, the local Member of Parliament and local councillors. Key performance indicators were used to discuss the ongoing hospital performance. Plans for the hospital were discussed and attendees were able to put forward their thoughts and ideas about the hospital.

Staff engagement

- Some staff attended the trust's 'listening into action' events and found them interesting. These had also been attended by the trust's Chief Executive. Listening into action was an engagement programme where trusts listen to their staff and involve them in identifying where improvements could and should be made. We did not see an action plan created as a result of these sessions.
- Staff told us the trust used snapshot surveys, mainly based on the staff survey outcomes. Results of these surveys were made available to staff. We did not see any outcomes of these surveys.
- Positive feedback from patients was shared with staff.

Outpatients and diagnostic imaging

- Staff said they received newsletters (Team Talk) monthly and emails to ensure they were kept informed about trust activity and plans. Staff said this had improved more recently and they now felt more engaged with the trust as a whole.
- Regular staff meetings were held in the outpatient and diagnostics departments. Treatment Centre staff had regular staff meetings with the surgical staff as they belonged to the surgical directorate. Staff described interactive meetings where ideas were shared and discussed.

Innovation, improvement and sustainability

- Staff felt the hospital was often picked to trial new innovations, for example, early discharge schemes and developing integrated working with community services.
- Diagnostic staff told us about planned replacement of some diagnostic equipment. They said this would improve the quality of results.

Outstanding practice and areas for improvement

Outstanding practice

- There was a very positive culture in all the departments we visited. Staff spoke of good teamwork and flexibility within the staff groups.
- Staff across all of the outpatient departments and we visited, including reception staff, were very patient-centred and made great efforts to ensure patients were supported, given time to ask questions and understood the information they had been given.
- The outpatient department had six volunteers. We saw them helping people around the department and to different parts of the hospital. We saw them spending time with patients who were waiting, helping to relieve their anxiety. The volunteers also provided drinks to patients who were waiting for their appointments. The outpatient department manager spoke very highly of their volunteers and the positive effect they had on patients who visited the department.

Areas for improvement

Action the hospital MUST take to improve

- Review all equipment in the surgical unit and theatres at West Cornwall Hospital and ensure it is serviced in line with manufacturer guidance. The asset registers should ensure a clear audit trail is maintained of date of last service and date due for next service.

Action the hospital SHOULD take to improve

- Ensure all staff are aware of the local procedure at West Cornwall Hospital for managing patients requiring overnight stay or transfer for escalation of care and ensure this process is well embedded and staff are able to access advice immediately if a patient is at risk. The surgeon and anaesthetist should be reminded to visit the ward to check all patients prior to them leaving site and handover to the medical team on site in line with the local procedure. The arrangements with the ambulance service and timely transfer of patients should be reviewed to ensure there are no risks to the patient and staff are not left feeling vulnerable.
- Ensure staff are confident in the response to emergencies through the use of simulation scenarios and use these to identify learning needs for processes and staff.
- Review the use of fabric reusable curtains in the surgical unit and the diagnostic imaging department and their implications on infection prevention control within the hospital.
- Consider a formal process for clinical supervision to ensure improvements in nurse practice and reflective learning.
- Continue to review the capacity at West Cornwall Hospital and the opportunities to increase theatre lists for the benefit of improving flow at Royal Cornwall Hospital and ensuring patients receive timely operation dates.
- The trust should ensure there are processes in place for induction and orientation when West Cornwall Hospital staff are relocated to Royal Cornwall Hospital for their shift. Consideration should be given to the safe staffing provided when staff are required to work on wards or departments which they have never experienced or are not comfortable to work in.
- Review the process for recording and managing risks relevant to theatres and the surgical unit at West Cornwall Hospital.
- Monitor the risks and practices put in place to reduce the risks for radiography staff when lone working out of hours.
- Make better use of the cardiology clinic capacity available at West Cornwall Hospital.
- Make data available, trust-wide, to show the proportion of patients that waited more than 30 minutes to see a clinician or what percentage of clinics started late.
- Display information about chaperones being available in all outpatient areas.

This section is primarily information for the provider

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment (1) All premises and equipment used by the service provider must be — e) properly maintained The provider had not taken adequate steps to properly maintain equipment. Clinical equipment at West Cornwall Hospital was identified as expiring their service dates. The clinical inventory for theatres and the surgical unit did not provide a clear audit trail for date of service and date of next service.