Care Quality Commission

Royal Cornwall Hospitals NHS Trust

St Michael's 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.

This is an announced focussed inspection of Royal Cornwall Hospitals NHS Trust to assess if improvements have been made following the previous unannounced focussed inspection carried out in January 2017.

St Michael's Hospital is located in Hayle and is one of the three acute hospital locations run by Royal Cornwall Hospital NHS Trust. St Michael's Hospital provides surgery and outpatient services. We inspected both services as part of this inspection on 5 July 2017.

We rated St Michael's Hospital as good overall.

Our key findings were as follows:

- Staff reported incidents and demonstrated knowledge of how to do this.
- Staff demonstrated how they learnt from never events which had occurred at the hospital and evidenced how changes to practice had been made.
- Patients were safely managed and staff identified and responded should a patient deteriorate. There was a good awareness of sepsis processes.
- The environments we visited were 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 in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements.
- In theatres good practice was observed with the efficient and timely completion of the five steps to safer surgery World Health Organisation checklist.
- Resident medical officers were available 24 hours a day, seven days a week to provide medical support to nurses when caring and treating patients.
- There was exceptional multidisciplinary team working which was co-ordinated and delivered with the involvement of necessary staff.
- Physiotherapy provided services seven days a week. An Enhanced Recovery After Surgery programme was delivered to orthopaedic patients and early mobilisation was encouraged which had reduced the length of stay for patients.
- Care and treatment was delivered in line with best practice and evidence based guidance.
- All staff were competent to carry out their roles and learning needs were identified during their annual appraisal. Staff reported they were well supported and encouraged in training opportunities for professional development and skills.
- Patients were repeatedly positive about the care and treatment they had received.
- We observed staff providing care which was compassionate and supportive. Patient privacy and dignity was always respected. Staff took time to interact with patients in a respectful and considerate manner and ensured that patients understood the care and treatment they were receiving.
- Staff understood and respected patient's personal, cultural, social and religious needs.
- Staff showed a supportive attitude to patients. When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way.
- There was good flow from theatres to wards. Theatres were well utilised and theatre lists were not restricted by bed capacity. Surgical cancellations were low at St Michael's Hospital.
- Information about the needs of the local population was used to inform how services were planned and delivered.

Summary of findings

- Patients' individual needs were taken into account and adjustments made for example longer appointment times were available for people living with dementia and for those with mobility problems, hearing difficulties and visual impairment.
- The culture across the hospital and all staff roles was overwhelmingly positive.
- Staff spoke positively about the local leadership team. This team promoted good quality care and were aware of the key risks and mitigations.
- There was a clear vision and strategy for St Michael's Hospital, this was discussed, along with other ways of improving the service, within the monthly St Michael's Clinical Programme Board.

We saw several areas of outstanding practice including:

- The structured and co-ordinated multidisciplinary team working in a nurse and therapy led unit ensured patients care and treatment was seamless. This aimed to and had achieved improving patient experience and patient outcomes. Seven day working and twilight hours of physiotherapy enabled the enhanced recovery after surgery programme to be delivered. Data showed an increase in standing and mobilising patients on the day of their surgery and reductions in the average length of stay for orthopaedic patients.
- There was an exceptionally positive culture amongst the staff working at St Michael's Hospital with a sense of good team spirit and flexibility within the staff groups.
- The happy and calm atmosphere enabled high standards of care to be provided to patients.
- Staff across all of the outpatient departments and we visited and 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.
- Patients were overwhelmingly positive about their care and treatment they had received.

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

Importantly, the trust must:

- Ensure staff investigating incidents are aware of the current guidance and the framework for reporting never events and comply with trust policy. The trust must review the never event incident of wrong side anaesthetic block at St Michaels Hospital in November 2016.
- Carry out a risk assessment and consider a long term solution to the ceiling tiles in the pre-operative assessment clinic waiting room to reduce the risk of them falling from the ceiling again.

In addition the trust should:

- Continue to review the security arrangements within the hospital, and seek feedback and confirmation from staff that they feel safe in their working environment.
- Ensure staff are checking and referring to the instrument list included with the set as part of the checking procedure in theatres during wound closure.
- Ensure medications are identified for return to pharmacy in a timely manner. Controlled drug expiry dates should be checked with the daily stock checks and patient own medication should be returned at the nearest point following discharge.
- Ensure chlorine tablets remain safely locked and are not accessible to patients and visitors.
- Review the use of fabric reusable curtains and their implications on infection prevention control within the hospital.
- Have in place a system to identify each individual prescription issued so that a prescription could be traceable if a problem arose in the future.
- Consider the security of the door to the pre-operative assessment clinic to prevent people being able to access the unit and the rest of the hospital without staff knowing and to maintain confidentiality of patient notes.
- Consider the need for call bells in the general outpatient consulting rooms.
- Ensure staff mandatory and local training gaps are addressed and compliance achieves trust targets.

Summary of findings

- Consider a formal process for clinical supervision to ensure improvements in nurse practice and reflective learning.
- The trust should ensure there are processes in place for induction and orientation when St Michael's 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.
- Continue to review the capacity at St Michael's 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.

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 demonstrated how they learnt from never events which had occurred at the hospital and evidenced how changes to practice had been made.
- Patients were safely managed and staff identified and responded should a patient deteriorate. There was a good awareness of sepsis processes.
- In theatres good practice was observed with the efficient and timely completion of the five steps to safer surgery World Health Organisation checklist.
- Resident medical officers were available 24 hours a day, seven days a week to provide medical support to nurses when caring and treating patients.
- There was exceptional multidisciplinary team working which was co-ordinated and delivered with the involvement of necessary staff.
- Physiotherapy provided services seven days a week. An Enhanced Recovery After Surgery programme was delivered to orthopaedic patients and early mobilisation was encouraged which had reduced the length of stay for patients.
- Care and treatment was delivered in line with best practice and evidence based guidance.
- Staff reported they were well supported and encouraged in training opportunities for professional development and skills.
- Patients were repeatedly positive about the care and treatment they had received.
- We observed staff providing care which was compassionate and supportive. Patients were interacted with consistently and it was ensured that patients understood the care and treatment they were receiving.
- Patient privacy and dignity was always respected. Staff took time to interact with patients in a respectful and considerate manner.
- There was good flow from theatres to wards. Theatres were well utilised and theatre lists were not restricted by bed capacity. Surgical cancellations were low at St Michaels Hospital.
- Peoples' individual needs were well considered and supported where applicable.

Summary of findings

- The culture across the hospital and all staff roles was overwhelmingly positive.
- Staff spoke positively about the local leadership team. This team promoted good quality care and were aware of the key risks and mitigations.
- There was a clear vision and strategy for St Michaels Hospital, this was discussed, along with other ways of improving the service, within the monthly St Michaels Clinical Programme Board.

However:

- There were instances where medicines were not identified for disposal and/or return to pharmacy in a timely manner. We found an out of date controlled drug and also out of date prescribed patient medication for discharged patients.
- We found one instance where chlorine tablets were unsecure on the ward; this was resolved immediately once raised.
- There was no security on site; this left some staff feeling vulnerable. However, senior staff and trust security were addressing these issues.
- Curtains were made from fabric and reusable which was not best practice for infection prevention and control.
- Staff were not all up to date with their mandatory and local training. Safeguarding children level two training compliance was low. However, children were not treated at St Michaels.
- There was no clear programme for staff clinical supervision.
- St Michael's hospital was not being used to full capacity to help improve the flow across the trust. However, a business case was in place to increase orthopaedic surgery, so there was potential for improvement in the future.
- There were financial restrictions to the vision and strategy for surgical services at St Michaels Hospital.
- Public engagement was limited to obtain views of patients to enable the service to be improved and developed.

Outpatients and diagnostic imaging

Good

We rated this service as good because:

- Staff reported incidents and demonstrated knowledge of how to do this.

Summary of findings

- The environments we visited were 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 appropriately.
- People's individual care records were stored securely in the outpatient's and X-ray service. The main reception area used computer records to book patients in when they arrived for their appointment the screen was not visible to patients and the paper clinic lists kept by the receptionist were kept covered so they could not be seen by patients.
- There were arrangements in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements.
- Staff were 100% compliant with their mandatory training.
- Staff received training to look after people in an emergency.
- The outpatient and X-ray services used relevant evidence based best practice guidance and standards to develop how services, care and treatment were delivered.
- The outpatient services and X-ray department participated in local and national audits, benchmarking and peer review.
- 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.
- All staff we spoke with reported good multidisciplinary working between different departments and other Royal Cornwall Hospital Trust (RCHT) hospital sites.
- The outpatient services at St Michael's hospital ran Monday to Friday between 9am and 5 pm. There were no weekend or out of hours services.
- Staff in all outpatient services were able to access relevant information to ensure they provided the appropriate care and support to patients.
- Staff understood and respected patient's personal, cultural, social and religious needs.

Summary of findings

- Staff showed a supportive attitude to patients. When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way.
- We saw 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 signpost people to external services who may be able to provide ongoing support
- 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 for people with dementia, mobility problems, hearing difficulties and visual impairment may be given longer appointment times.
- There was and pay and display parking, with disabled spaces. There was a drop off area at the main reception as the car park was a short walk away.
- 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 via 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.
- Referral to treatment times were overall better than the England average. Once in the outpatient departments patients did not have to wait long before they were called in to see their clinician.
- There was information displayed and available about how to make a complaint or raise a concern.
- The local management team were well respected. They supported their teams and promoted good quality care. The departments we visited were well organised and had a calm feel.

Summary of findings

- There was a very positive culture in all of the outpatient departments we visited.
- There was a clear vision for the general outpatient and physiotherapy areas which were being redesigned and refurbished.
- Staff felt informed about activity across the trust as a whole.
- Through a programme of audit and work streams areas for improvement were identified and changes implemented.
- Public engagement was ongoing and the hospital had a very active League of Friends.

However:

- Individual records of each prescription issued were not kept. This meant that prescriptions might not be traceable if a problem arose in the future.
- There was a potential for a breach of confidentiality in the pre-operative assessment clinic. It was accessible to the general public who may be able to access patient records if they were left unattended in the clinic.
- In the pre-operative clinic waiting room tiles had fallen from the roof on at least two occasions and as recently as four weeks prior to the inspection. Staff told us the tiles have been replaced but no investigation had been carried out as to why they had fallen and there was no risk assessment in place

There were no call bells in the general outpatient consulting rooms.

St Michael's Hospital

Detailed findings

Services we looked at
Surgery; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to St Michael's 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 532,273 people, a figure that can be doubled by holiday makers during the busiest times of year.

St Michael's Hospital is located in Hayle and is one of the three acute hospital locations run by Royal Cornwall Hospital NHS Trust (the others being The Royal Cornwall Hospital, Truro and West Cornwall Hospital, Penzance).

St Michael's Hospital provides surgical inpatient care and treatment for patients requiring orthopaedic and breast surgery. The hospital also provides diagnostic and therapy services and a wide range of outpatient clinics including ear, nose and throat (ENT), urology, orthopaedics and audiology. There are X-ray services onsite.

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 St Michael's Hospital team included CQC inspectors, an 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 variety 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 St Michael's Hospital on 5 July 2017 to inspect surgical services and outpatients and diagnostic imaging, and revisited on 7 July 2017.

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 fifteen members of staff including: consultants, trained nurses, radiographers, physiotherapists and reception staff. We talked with six patients and their representatives who were attending the hospital.

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

Facts and data about St Michael's Hospital

St Michael's Hospital completes 80% of Royal Cornwall Hospitals Trust's orthopaedic work and the majority of breast surgery. There are four theatres; three for orthopaedic surgery and one for breast surgery, which operate each week day and on occasional Saturdays. Two wards are within the hospital which includes a 24 bedded/seated admission and day case ward and a 28 bedded inpatient ward. The hospital provides a nurse and therapy led seven day service. Surgery at St Michael's Hospital was provided to adults only.

An outpatient service was also provided at the hospital which includes pre-operative assessment clinics and a wide range of speciality outpatient clinics. Between July 2016 and June 2017 there were 26,799 outpatient appointments and 14,868 diagnostic procedures (X-rays) carried out at St Michael's Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

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

Information about the service

Surgical services are provided at St Michael's Hospital, and include breast and orthopaedic procedures for elective patients who are pre-assessed against admission criteria. The hospital completes 80% of the trust's (Royal Cornwall Hospital Trust) orthopaedic work and the majority of breast procedures for patients with no co-morbidities. Between 1 January and 31 May 2017 St Michaels Hospital saw 726 elective inpatients, 1304 day cases and four emergencies.

There are four operating theatres (one breast and three orthopaedic), one recovery ward and two surgical wards. The wards include; St Michael's, a 24 bedded/seated admissions and day case ward, and St Joseph's, a 28 bedded inpatient ward. The surgical wards are nurse and therapy led with a resident medical officer providing 24 hour medical support.

We visited the hospital for one day and one morning, and spent time in theatre and on the wards. We spoke with 38 staff including; hospital manager, ward sister, theatre manager, ward managers, staff nurses, student nurses, health care assistants, operating department practitioner, theatre assistants, consultant surgeons, consultant anaesthetists, resident medical officers, physiotherapists, occupational therapists, ward clerks, receptionists, a volunteer and cleaning staff. We also held a staff focus group, 22 staff from across the hospital attended.

We observed patient care and obtained feedback by talking to 16 patients and three relatives. We reviewed seven patient records. Both prior to and following the inspection we reviewed data and information provided by the trust and hospital.

During the last inspection, in January 2016, we rated this service as good overall with requires improvement in safe.

Surgery

Summary of findings

We rated this service as good because:

- Staff demonstrated how they learnt from never events which had occurred at the hospital and evidenced how changes to practice had been made.
- Patients were safely managed and staff identified and responded should a patient deteriorate. There was a good awareness of sepsis processes.
- In theatres good practice was observed with the efficient and timely completion of the five steps to safer surgery World Health Organisation checklist.
- Resident medical officers were available 24 hours a day, seven days a week to provide medical support to nurses when caring and treating patients.
- There was exceptional multidisciplinary team working which was co-ordinated and delivered with the involvement of necessary staff.
- Physiotherapy provided services seven days a week. An Enhanced Recovery After Surgery programme was delivered to orthopaedic patients and early mobilisation was encouraged which had reduced the length of stay for patients.
- Care and treatment was delivered in line with best practice and evidence based guidance.
- Staff reported they were well supported and encouraged in training opportunities for professional development and skills.
- Patients were repeatedly positive about the care and treatment they had received.
- We observed staff providing care which was compassionate and supportive. Patients were interacted with consistently and it was ensured that patients understood the care and treatment they were receiving.
- Patient privacy and dignity was always respected. Staff took time to interact with patients in a respectful and considerate manner.
- There was good flow from theatres to wards. Theatres were well utilised and theatre lists were not restricted by bed capacity. Surgical cancellations were low at St Michaels Hospital.
- Peoples' individual needs were well considered and supported where applicable.
- The culture across the hospital and all staff roles was overwhelmingly positive.
- Staff spoke positively about the local leadership team. This team promoted good quality care and were aware of the key risks and mitigations.
- There was a clear vision and strategy for St Michaels Hospital, this was discussed, along with other ways of improving the service, within the monthly St Michaels Clinical Programme Board.

However:

- A missed never event was identified during the inspection. This incident was not reported as a never event despite meeting the criteria. Incorrect guidance was followed which was not consistent with corporate policy.
- There were instances where medicines were not identified for disposal and/or return to pharmacy in a timely manner. We found an out of date controlled drug and also out of date prescribed patient medication for discharged patients.
- We found one instance where chlorine tablets were unsecure on the ward; this was resolved immediately once raised.
- There was no security on site; this left some staff feeling vulnerable. However, senior staff and trust security were addressing these issues.
- Curtains were made from fabric and reusable which was not best practice for infection prevention and control.
- Staff were not all up to date with their mandatory and local training. Safeguarding children level two training compliance was low. However, children were not treated at St Michaels.
- There was no clear programme for staff clinical supervision.
- St Michael's hospital was not being used to full capacity to help improve the flow across the trust. However, a business case was in place to increase orthopaedic surgery, so there was potential for improvement in the future.
- There were financial restrictions to the vision and strategy for surgical services at St Michaels Hospital.
- Public engagement was limited to obtain views of patients to enable the service to be improved and developed.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- Staff confidently spoke about the learning from never events specific to their team and the changes in practice as a result.
- The environment appeared to be clean, tidy and well maintained. Staff were compliant with infection control practice.
- Equipment was in good working order and clearly labelled with dates of service. All resuscitation equipment was checked regularly and confirmed fit for purpose.
- Resident medical officers provided medical support to the wards 24 hours a day, seven days a week.
- Regular observations and risk assessments were completed for patients to ensure deteriorating patients were identified in a timely manner and transferred promptly to receive further care and treatment.
- Staff had a good awareness of sepsis and the processes to follow to escalate if a patient was identified for sepsis.
- In theatres good practice was observed with the efficient and timely completion of the five steps to safer surgery World Health Organisation checklist.

However:

- A missed never event was identified during the inspection. This incident was not reported as a never event despite meeting the criteria. Incorrect guidance was followed which was not consistent with corporate policy.
- In one instance we observed the instrument list with the set was not being referred to when the team were calling the name and number of the instruments on the set.
- On one ward some medicines for disposal and/or return to pharmacy were not identified in a timely manner. We found an expired controlled drug and prescribed patient medication for discharged patients.
- We identified an isolated case were chlorine tablets were found unsecure on one ward; this was resolved during the course of the inspection.
- There was no security on site, this left some staff feeling vulnerable. However, senior staff and trust security were addressing these issues.
- Staff were not all up to date with their mandatory and local training. Safeguarding children level two training compliance was low. However, children were not treated at St Michaels Hospital.
- Curtains were made from fabric and were not disposable this is not best practice for infection prevention and control.

Incidents

- Five never events had been reported within the surgery service for the trust between October 2016 and June 2017, of these one never event was happened at St Michaels Hospital. This was reported as wrong site surgery where the incorrect excision had been made. All staff within the hospital were aware of this never event and the resulting learning. Changes were implemented to practice following this never event and the specialty specific five steps to safer surgery World Health Organisation (WHO) surgical checklist had been amended to include increased checks on the management of specimens and the identification of margins for excision. This was in draft and awaiting final approval before becoming a live document. Staff were also aware of the never events which had occurred at other trust sites and had been informed of the learning and changes in practice which had resulted.
- During the inspection we identified a missed never event. An incident at St Michaels Hospital was not correctly reported as a never event. This incident was a wrong side anaesthetic block which happened in November 2016. We raised this with the hospital following the inspection who informed us wrong side anaesthetic blocks were removed from the never event list and therefore would not have been declared as an incident. However, the current never event list 2015/16, which should have been used at the time of the incident, includes wrong site blocks. We further raised this with the trust who revisited this incident with the divisional senior management team and the incident investigator and concluded that this incident did meet the never event criteria at the time of reporting. At the time of the incident the team had referred incorrectly to the 2013/14 never event framework where wrong site blocks had been removed. Wrong site blocks had been re-introduced in March 2015. The divisional team had

not used the correct framework and therefore were not following the trust's corporate policy updated in April 2016 which clearly states the use of the 2015/16 never events list. The trust confirmed the incident will be declared retrospectively. The trust also confirmed at the time of the incident a local investigation was completed by another consultant anaesthetist who concluded the stop before you block protocol was not followed, the incident was subsequently discussed at the anaesthetic governance meeting.

- Staff spoken with discussed historic never events with their implications to theatre and how their occurrence altered practice. For example, a never event where an incorrect prosthesis was implanted. Changes in practice resulted, including: the prosthesis required by the surgeon being recorded on the swab board in theatre, this then being checked by the circulator, scrubbed practitioners, and surgeons, before implantation takes place. The change in practice was based on recommendations of National Institute for Health and Care Excellence (NICE) and Association for Perioperative Practice (AfPP) for safe practice, and was audited for a year to ensure it was embedded in departmental practice.
- Staff were encouraged to report incidents and were able to demonstrate to us the type of incidents which were reportable. Staff felt the incident reporting culture was good and people were proactive at responding to issues.
- Staff felt they received satisfactory feedback and they endeavoured as a team to learn from incidents so they did not reoccur. Managers disseminated learning from incidents to staff and these were discussed at departmental meetings.
- Incident themes included; holes in sterile sets, falls from patient fainting post operatively, and patients not being appropriate to transfer from Royal Cornwall Hospital to St Michaels Hospital. Because of incidents surrounding inappropriate transfers, changes were made to practice. Staff were informed they must ensure a thorough handover between medical staff and between nursing staff prior to the transfer, and be confident to discuss and not accept if not deemed safe.
- 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

- Staff we spoke with had a variable level of understanding of the terminology duty of candour. The 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. Despite staff not always understanding the terminology, nearly all staff were able to tell us that if something went wrong they would make sure they were open and honest with the patient, and ensure that the appropriate people were informed. Some staff told us how they had been encouraged and supported to deliver the principles of duty of candour including being open, offering an apology, and following this up with a letter.

Safety thermometer

- The level of patient harm was low at St Michaels Hospital. The safety thermometer was used to monitor the level of patient harm for St Josephs' inpatient ward on one day of each month. The safety thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm free care'. This includes falls, pressure ulcers, catheter associated urinary tract infections (UTIs) and venous thromboembolism (VTE). St Michael's ward the day case unit was not required to submit this data.
- Safety thermometer data provided monthly between January and June 2017 evidenced low levels of patient harm. There were no falls with harm, three falls with no harm, three old (defined as being present before patient came under care of the hospital or within 72 hours of admission) pressure ulcers, one old UTI from catheter, and four additional UTIs. VTE prophylaxis was achieved in 99% of cases and VTE risks assessments were completed in 100% of cases.

- The number of falls and number of pressure ulcers sustained were displayed clearly in St Josephs' Ward. At the time of our inspection, for the four days that had passed in July, the ward had reported no new pressure ulcers and no new falls.

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.
- All surgical and ward areas appeared visibly clean, tidy and well maintained. This included corridors, bed spaces and equipment. Responsibility for cleaning the hospital was shared between contracted cleaning staff and nursing staff. Cleaning staff were available from 7am to 7pm and as well as daily cleaning, would undertake deep cleaning if there was a risk of infection or a patient was moved. Some contracted cleaning staff members we spoke with reported that due to staff shortages they now had to complete additional work within the same time frame and thus the same standard of cleaning could not be maintained.
- Regular cleaning audits were undertaken to assess compliance, with theatres being audited weekly and wards monthly. This audit was undertaken by both nursing and cleaning staff. We saw the most recent audit for St Joseph's ward which showed 100% nursing compliance, 100% estates compliance and 99.64% cleaning service.
- Some daily checklists stored on St Michaels ward were not complete. Daily cleaning should be undertaken of the commodes, portable oxygen and suction unit. However, for the time period 22 May to 16 June 2017 there were missing entries for all three checks on numerous days each week. We were therefore not provided with assurance that these were cleaned regularly as required.
- Staff were compliant with infection control practices to prevent the spread of infection as per National Institute for Health and Care Excellence guidance. 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. Equipment was identified as clean using 'I am clean' stickers, this were observed to be recently dated.
- In theatres we observed good infection control practice and sterility was maintained through the use of drapes and gowns which were all disposable.
- Hand hygiene audits were completed on a monthly basis with the most recent results being displayed in wards and theatres. Hand hygiene audits for May and June 2017 were 100% compliant for pre-assessment, theatres, theatres recovery, St Joseph's inpatient ward, St Michael's day case ward, and therapy services.
- Infection control risk assessments were completed for patients on admission. Patients were routinely screened for MRSA through taking a swab of the nose, groin and wound, also swabs were taken of any other invasive areas or catheter/cannula. Data showed for April and May 2017 all but one patient was screened for MRSA.
- Patients could be isolated if they had a known or suspected infection. There were no side rooms, therefore patients would need to be isolated in a bay which had capacity for four patients. Deep cleans were completed once the bay was vacant before patients were moved to the bay.
- The cleaning of linen was carried out by an external organisation. Dirty linen would be stored prior to collection. Clean linen would then be returned to the hospital.
- Curtains on wards were reusable fabric rather than disposable. 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.
- 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.
- Theatres were laminar flow (a constant flow of air in and out of theatre), evidence suggests the laminar air flow system reduces bacteria and microorganisms and therefore controlling infection in the theatre. This reduces the risk of surgical site infections, particularly in orthopaedic surgeries.

- 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

- Equipment was observed to be in good working order and clearly labelled with date of service. All equipment we viewed was within its servicing date. The trust maintained an inventory of clinical equipment, to include fixed, mobile and portable devices. Staff were employed to oversee maintenance related activity or maintenance would be completed as part of a contract with the manufacturers or third party. New equipment was subject to a formal acceptance process in line with Medicines and Healthcare products Regulatory Agency guidance.
- 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 trolleys were tamper evident and weekly checks to confirm all equipment was available and in date. We saw evidence of these checks being completed with only minimal gaps in recording. 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.
- In theatres the difficult airway trolley was easily accessible from the corridor.
- 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. One locum anaesthetist told us they were happy with the anaesthetic equipment available, they felt it was well maintained with replacements available should this be necessary.
- Sterile instrument sets for operations were provided from the sterilising department at Royal Cornwall Hospital. Staff ensured there were adequate numbers of instrument sets through advanced planning. However, staff told us how problems or delays arose when the protective outer wrapping of sets were found to have holes, therefore compromising sterility, with no replacement available on site. Staff felt it was due to the transportation of the equipment between the hospitals and incident reporting for St Michaels Hospital reflected this. The theatre manager told us that a number of protective metal cases had been ordered to reduce this issue.
- The management of medical devices was safe. Prosthesis implants were documented in patient records using designated labels.
- Random checks of stock and consumables confirmed stock was in date and in good condition. Ward stock and consumables were stored in an orderly fashion. In theatres we observed an open storage cupboard, which posed a risk of dust accumulation on stock.
- The hospital did not admit patients with a body mass index (BMI) exceeding 40 as they were unable to safely treat these patients in the absence of bariatric equipment. Day cases could be taken with a BMI below 40 and inpatients a BMI below 35. A hoist was available on wards and could carry patient weight up to 205kg.
- The environment was designed and maintained to keep people safe. There were clear routes for fire exits which were appropriately signposted above the exit.
- During our visit the temperature in one theatre rose to 28 degrees Celsius, resulting in one patient being cancelled at the end of the list. At the time of our inspection engineers were attending to this issue and contingency plans were made for the following day by the theatre manager.
- In theatres there was a storage problem in relation to large equipment which was kept in the main corridor, this had implications to the access for both patients and staff. Staff endeavoured to maintain a clear passage for patients and theatre traffic, however there was a potential risk in an emergency this area could compromise ease of movement.
- We did identify the unsafe storage of disinfectant chlorine tablets, which are hazardous to health if swallowed. These were in an unlocked sluice on St Joseph's ward and could be accessible to patients or visitors. We raised our concerns to the Sister who responded appropriately to ensure these remained locked within the sluice. When we visited two days later the chlorine tablets remained locked.
- There was no on site security staff. Some staff mentioned they felt vulnerable when working night shifts, particularly when locking the hospital once visitors had left. Changes had been implemented to improve staff safety, for example visiting hours were

changed so visitors left earlier, this enabled one member of staff from the day shift and one member of staff from the night shift to lock up, rather than one person doing this alone. Staff told us how they would dial 999 in the event of a security concern as although they can contact trust security they are a 40 minute drive away. CCTV of locations around this site, including the front door, was available to view on the wards. We observed a meeting between senior members and security where an action plan was put in place to address ongoing concerns.

- Waste was being managed safely with appropriate segregation and storage. Clinical waste was disposed of in clinical waste bags and stored for collection. None of the waste bins or containers we saw were unacceptably full. Sharps were disposed of in sharps bins, sharps bins were not left out on wards and were obtained as and when needed from non-patient areas.

Medicines

- Controlled drugs and stock medicines were stored securely, safely handled and administered. These medicines on wards were locked and the key was held by a nurse. In theatres controlled drug cupboards were observed to be locked when staff were not present and keys were held by registered practitioners.
- Medicines were not always identified for disposal and/or return to pharmacy in a timely manner. We identified on St Joseph's ward, palladone 1.3mg, a controlled drug, had expired by five days. Although this medicine had not been administered since the expiration date, the nursing team had failed to identify the expired medicine during their daily controlled drug checks. The medicine was returned to pharmacy during our inspection. We also found prescribed patient medication stored in the fridge, these patients had been discharged from the ward but their medications had not been returned to pharmacy.
- 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. On St Joseph's ward, nursing staff completed twice daily controlled drugs checks, which were complete, with minimal gaps where the second daily check had not been recorded. On St Michaels ward nursing staff completed daily checks, these were mostly complete, however six daily checks were absent in June 2017 and seven daily checks in May 2017, of which five were on a Tuesday. In theatres stock levels were checked prior to surgery and at the end of the list, should there be a change of staff the drugs would be re-checked. We confirmed theatre controlled drugs registers were appropriately completed. Controlled drugs were returned to pharmacy for disposal.
- Emergency drugs were available in recovery and on the ward, a random check identified these were in date.
- Medicine stock on wards was in an orderly fashion, random checks confirmed medicines were in date.
- Fridge temperatures were monitored, either through daily checks or a link to pharmacy quality assurance 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.
- Allergies were clearly documented within patient documentation and electronic prescription charts. On admission nursing and medical staff confirmed any patient allergies with the patient.
- We observed a medication ward round, the nurse wore a tabard which indicated they should not be disturbed to ensure the safe administration of medication. The nurse checked if patients required pain relief or anti-sickness medication as prescribed, additional to their regular prescribed medication. The nurse explained to the patient any new medication, why it was required and how to take it, for example with food.
- Medical gases were safely stored in purpose made holders above floor height.
- Pharmacy support was available from the trust team based at Royal Cornwall Hospital. Staff felt pharmacy provided a good service. Staff said pharmacy dealt effectively with requests required urgently. We observed the theatre manager informing their team of a drug alert cascaded by pharmacy. Pharmacy attended on a flexible arrangement approximately every two weeks and would pick up any issues on attendance. Pharmacy undertook annual safe storage of medicines audit in addition to monthly audits undertaken by ward staff.

Records

- Records were stored securely to ensure patient confidentiality. Records available for patients on the ward were held under key pad lock, we observed staff accessing records and locking immediately. 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, complete, legible and up to date. We reviewed seven patient records for discharged patients.
- We reviewed three sets of patient records when in theatre and confirmed documentation was relevant to the procedure being completed.
- Risk assessments were completed for each patient. This included; infection control, falls, pressure ulcer, venous thromboembolism, nutritional, manual handling and bed rails.
- Patients received a pre-operative assessment, these were completed in full in the seven records we reviewed. Staff did comment on the repetition this document required.
- The multidisciplinary team, to include nursing, medical and therapy staff, documented the care and treatment they provided to patients in one record per patient. This was clearly documented to ensure care and treatment was communicated between staff and information was easy to find.
- Tracking labels were added to patient records to ensure identification of any equipment used during the surgical procedure.
- Records were audited as part of the monthly nursing quality indicators, reportable via the clinical dashboard. For April and May 2017 compliance was at 98%. For June 2017 compliance was 82%, this was mainly due to unnecessary abbreviations and jargon identified in records and gaps in completion of the nursing assessment and discharge planning document.

Safeguarding

- Staff were confident in the systems, processes, and practices for safeguarding. Staff understood their responsibilities and adhered to trust policies and procedures.
- Staff felt supported by the trust safeguarding team and in raising concerns. Staff had good knowledge of the safeguarding leads within the trust and where they could find the appropriate information. Staff reported if they had any uncertainty over their concerns they would raise the matter with their manager or an appropriate member of staff for guidance and advice.
- We heard of one example where a safeguarding concern was addressed in relation to concerns surrounding a patient and their relative. The staff worked with the local safeguarding teams and safeguarding leads in the hospital to ensure any safeguarding concerns were addressed and the appropriate action was taken for the patient's safety.
- Training records dated 31 May 2017 showed staff compliance with safeguarding training required improvement. For staff working on St Michaels and St Joseph's ward and in theatres safeguarding adults level one was above the trust target of 95% at 97% compliance. For safeguarding adults level two training eight staff were not up to date resulting in 89% compliance, and for safeguarding children level one 16 staff were not up to date so compliance was 79%. We confirmed the three contracted resident medical officers had completed safeguarding training adults level one and two and safeguarding children level one.
- Records showed the three resident medical officers had not received updated safeguarding level two children training and only 51% of staff on wards and in theatre were up to date with this training. As per the safeguarding children and young people intercollegiate document, level two safeguarding training should be completed by all non-clinical and clinical staff who have any contact with children, young people and/or parents. This therefore includes nursing, clinical and allied health professional staff working in adult services.

Mandatory training

- Training compliance did not meet the required level for all local and mandatory training modules. The trust set a target of 95% compliance. We were provided with data which was dated 31 May 2017 for staff working in the wards and theatres at St Michaels Hospital. Compliance was above the trust target for equality diversity and human rights, non-patient manual handling, medicines management, mental capacity act and safeguarding children level one. Compliance was below the trust target for conflict resolution (91%), infection prevention and control (79%), duty of candour (88%), fire safety (77%), health and safety (80%), patient manual handling

(88%), resuscitation basic life support (78%), information governance (84%), safeguarding adults level two (89%), safeguarding children level one (79%) and safeguarding children level two (51%).
- The three resident medical officers undertook mandatory training, and were compliant with most modules with the exception of: one not being compliant with conflict resolution, two not being compliant with manual handling, and all three not being compliant with safeguarding children level two.
- Mandatory training was available online or face to face. Most staff reported they were given the time to attend training sessions when classroom based learning and it was engaging and responsive to their needs. However the electronic based learning was difficult to access due to the computer programme and they found it difficult to take time out when on shift to complete the required training.
- Theatre staff told us they regularly completed training on their audit days which were days in the month were they were able to undertake non-clinical work and training related to their roles.

Assessing and responding to patient risk

- Risks to people who use the service were assessed and safely monitored. An admission criteria for patients ensured only patients with stable medical conditions were treated at St Michaels 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 St Michaels Hospital if they were classified as ASA1, a normal healthy patient, or stable ASA2, a patient with mild systemic disease. St Michaels Hospital did not have a high dependency unit or a stable medical infrastructure to treat patients outside of ASA1 and stable ASA2 classification. Very occasionally emergency patients were treated at St Michael's Hospital who may breach the admission criteria, this was risk assessed and ensured adequate medical staff to support.
- 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. However, at St Michael's Hospital pre-operative assessment clinic this was not always possible due to the occupational therapy team being short staffed, and therefore assessments needed to be completed over the phone. We were told this could impact on the patient having appropriate equipment available post-surgery. Assessments were all checked by the anaesthetist. 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. Electronic devices were used to input NEWS which alerted if any high or concerning scores. We saw evidence in patient records of NEWS completed in recovery and observed NEWS observations being completed on wards. NEWS observations were also recorded within nursing evaluation sheets.
- We witnessed a health care assistant monitoring the patient and recording observations, the health care assistant was confident to raise their concerns to the resident medical officer when the patient's blood pressure was low. The resident medical officer immediately responded.
- 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. Should patients trigger for sepsis they would be transferred to Royal Cornwall Hospital. We were provided of examples of early recognition of sepsis markers and quick response by nursing staff and resident medical officer to transfer patients to Royal Cornwall Hospital for further treatment. A sepsis grab box was available on the wards.
- Pre-operatively medical staff reviewed patient records, checked their consent to the procedure and marked the surgical site or side.
- We observed good practice in theatres with the use of five steps to safer surgery, World Health Organisation (WHO) surgical checklist. The WHO procedure was correctly undertaken in a timely and efficient manner. When in theatre we reviewed completed forms which were signed and dated, with the exception of one

theatre practitioner's signature. On review of archived records, the WHO checklist was complete in five out of seven forms, two forms had missing signatures from the senior operating surgeon.

- 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 April 2017 compliance for St Michael's Hospital monthly was 98% and above. As a result of a high 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.
- We observed the stop before you block protocol being used. This is a national patient safety initiative to reduce incidents of wrong sided nerve block during regional anaesthesia.
- Team briefings were held at the start of each list. We observed a team brief where it was discussed how a patient had drunk a coffee and therefore would need to be seen later in the list. All lists were removed from theatre and retyped to ensure there was no confusion following the amendments.
- Safe practice was mostly undertaken during care delivery, counting and recording of swabs, needles and instruments in accordance with the Association for Perioperative Practice (AfPP) guidelines. However, when observing one operation the instrument list with the set was checked during preparation and signed, but on closure the list did not appear to be used and referred to by the circulator as the scrub nurse called the name and number of the instruments on the set.
- There were clear processes in place to assess and manage a deteriorating patient who was clinically unwell. There was a trust wide policy named 'clinical policy for safe transfer of patients between care areas or between hospitals' and a local St Michaels Hospital flow chart. Staff were able to confidently describe the processes involved. Patients would be transferred to Royal Cornwall Hospital to receive medical care. Staff told us there was an agreement in place with the ambulance service to blue light patients at the medical team's request, from St Michaels Hospital to Royal Cornwall Hospital, an 18 mile trip. We were 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. Should a patient deteriorate in recovery and require intubation the anaesthetist would accompany the patient in the ambulance.
- Data from 1 January to 12 July 2017 showed two patients were transferred from St Michael's Hospital to Royal Cornwall Hospital, one patient was transferred to critical care. Patients were transported in a timely manner, the time between the patient being identified for transfer and arrival at Royal Cornwall Hospital was 35 minutes and 41 minutes.
- The resident medical officer and nurses in charge carried the on call bleep to respond to an emergency resuscitation call. These bleeps were tested weekly to ensure they were in working order. Simulation scenarios were held annually during audit sessions when there was no planned surgical activity, sessions included three scenarios; major haemorrhage in theatre, patient deterioration cardiac arrest in recovery and anaesthetic room anaphylaxis. Following these sessions immediate learning was identified and changes made as a result. For example some staff were unaware of the internal call system and did not recognise the alarms, therefore a follow up session was required. We reviewed a report from a simulation scenario on 14 June 2016 which included observations and further discussions held to improve the emergency care provided. Some staff felt emergency scenarios were only practised occasionally and the frequency could be improved.
- During our inspection we observed staff on St Joseph's ward responding rapidly to an emergency call bell. This was in response to a patient fainting.
- Patient temperature was monitored in theatres and could be maintained to prevent hypothermia. Warming devices were used in both theatres and recovery.
- Blood was available in the event an emergency blood transfusion was required. The hospital held O negative blood, the blood cells are universal meaning they can be transfused to almost any patient.
- We observed detailed handovers of patient care by the anaesthetist to recovery staff, and recovery staff to the ward staff. This included the name of patient, type of surgery, condition during surgery, medication given, wound site, dressings, conscious levels and National Early Warning System scores.

- Risk assessments were completed for patients. To include; falls, pressure ulcers, nutritional, bedrails, venous thromboembolism and manual handling.
- Although the prevalence of pressure ulcers was low, pressure relieving equipment was available should it be required. The hospital could access the trust's tissue viability nurses and there was a tissue viability link nurse at St Michaels Hospital. Patients were encouraged in early mobilisation to decrease the risk of pressure ulcers.
- Falls were occasional and these were mostly due to patients fainting post operatively. Physiotherapists and nurses were competent at recognising signs and risks of falling. We saw one physiotherapist discuss with the patient the risk of falls, particularly as the patient mentioned previous falls. The physiotherapist assessed the patient and signposted to services which could be helpful.
- Venous thromboembolism (VTE) was risk assessed for patients and anti-embolism stockings were provided. Booklets were provided to patients to provide information on reducing the risk of VTE in hospital and following discharge.
- Good practice was observed where the physiotherapist checked the range of movement in the knee and muscle strength before mobilising the patient. They progressed the care and treatment in an appropriate way by use of a walking frame and then elbow crutches to progress the patient's recovery.
- The physiotherapy service reviewed orthopaedic patients post operatively once they were discharged from hospital. They would ask about the wound site and if there were any concerns they would refer the patient to their GP or an outpatient consultant clinic appointment.

Nursing and therapy 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. St Michaels Hospital was nurse and therapy led. A safe care report for the inpatient ward reviewed daily staffing levels compared to patient acuity. At the time of our inspection, wards and theatres were fully staffed to the required nursing establishment and skill mix.
- There was a staffing vacancy in the physiotherapy team which was being recruited into and a staffing vacancy in the occupational therapy team which was not being recruited into and was to be removed from the staff numbers. One occupational therapist told us how this meant they are regularly understaffed, which resulted in some difficulty providing face to face contact at pre-operative assessment and so in some cases a phone call assessment had to be made to patient before admission. This sometimes impacted on the appropriate equipment being available to patients after their surgery and so delaying discharges.
- Arrangements for handovers and shift changes ensured people were safe. The nursing handovers conveyed important information about patients between shift changes. We observed a nursing handover between the night shift and day shift. An initial safety briefing was completed, identifying observations and catheters, and any important information to note about patients, the hospital, wards, or theatres. This followed with a detailed patient handover discussing medications, pain levels, hydration, discharge plans, bloods, requirements for X-ray, and patient status and well-being.
- Agency and bank usage was occasional. However, staff were not aware of an induction process or checklist to use to orientate these staff to the wards. Between April 2016 and June 2017 there were none, one or two whole time equivalent agency staff used each month in theatres, there were no whole time equivalent agency staff on the inpatient wards with only 99 hours of agency used in this 15 month period on the ward.
- Due to fluctuations in work load it was a regular occurrence for nursing staff to be relocated for specific shifts from St Michael's Hospital to support Royal Cornwall Hospital. Staff reported mixed experiences of this. Some staff did not feel comfortable when they were placed on wards outside of their expertise or comfort zone, for example a healthcare assistant explained how they were placed on a maternity ward, another on a neurological ward, and these wards were not where they would normally work. Other staff told us how once they arrived at Royal Cornwall Hospital they were not always busy and felt they would have been better utilised staying at St Michael's Hospital. Not all staff received an induction to the areas they were working at Royal Cornwall Hospital, however staff recognised the pressures faced by Royal Cornwall Hospital and the gratitude of the staff on the wards they supported.

Surgical staffing

Surgery

- Medical staffing was based on the resident medical officer role. There were three resident medical officers in post with one position vacant at St Michael's Hospital, this position was currently being covered by a locum. The resident medical officers were trust grade doctors which is a term applied to a doctor who is working in the NHS in a non-training post, at senior house officer level.
- The resident medical officers each worked 12 hour shifts so two resident medical officers would cover a 24 hour period. Any shifts the locum was unable to work was covered by two of the three employed resident medical officers. Staff reported the work level was manageable most of the time and they felt supported by senior staff members, however if the ward was full they felt pressured due to the workload.
- The resident medical officer covered the inpatient ward day and night, and provided support as required to the day case ward. They supported admissions and preparation of patients for the theatre lists. Between shifts resident medical officers handed over to each other, providing information on patients, their care and treatment required and any concerns.
- The resident medical officers had a clinical line manager who was a consultant hand surgeon, and were also supported by the orthopaedic clinical director. Operating consultants on site provided help to the resident medical officers as and when required. Out of hours the resident medical officer would contact the on-call trauma team at Royal Cornwall Hospital. Resident medical officers said they felt supported by the consultants.
- Consultant surgeon and anaesthetist cover was provided in line with theatre specialty lists. Consultants would visit patients pre-operatively and perform the surgical procedure. Post-operatively consultant input was only provided should there be a concern with a patient or at the resident medical officer's request. Staff told us the anaesthetist remains in the department until all patients are stable.
- Due to the vacancies in trust wide anaesthetists, locum anaesthetists were regularly required to operate at St Michael's Hospital.
- We saw speciality doctors supporting surgeons with theatre lists. One speciality doctor told us they felt supported in their role and consultants were approachable.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents in the local area. The trust had a major incident plan with clear roles and plans specific for St Michaels Hospital. Key staff knew where to find and access the policy and the role and responsibilities they had in the event of a major incident. For example, in the event of certain emergency situations the hospital would take direction from the trust or the local ambulance service.
- Emergency generators were in use at the hospital, and tested regularly, in the event of a power cut.

Are surgery services effective?

Good

We rated effective as good because:

- Exceptional multidisciplinary working was observed, care and treatment was co-ordinated and necessary staff were involved in assessing, planning and delivering patient care and treatment.
- Physiotherapy services were provided seven days a week with twilight sessions. They provided an Enhanced Recovery After Surgery programme for orthopaedic patients. With increased physiotherapy support the hospital had seen improved patient experience and outcomes with standing and mobilising patients on the day of their surgery and a decreased length of stay.
- Orthopaedic patients were encouraged to mobilise early on post operatively and were supported to do this by therapy and nursing staff.
- Care and treatment was delivered in line with best practice and evidence based guidance.
- Pain was well managed and patients had timely administration of pain relief.
- Discharge summaries were promptly completed, sent to the GP, and detailed to ensure GPs and other healthcare providers could effectively continue the onward care for the patient.
- Staff reported they were well supported and encouraged in training opportunities for professional development and skills.

However:

- There was no clear programme for staff clinical supervision.

Surgery

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. Theatre staff were involved with the writing of standard operating procedures supported by evidence through AfPP recommendations and NICE guidelines.
- The physiotherapy service was based on evidence based practice delivering the Enhanced Recovery After Surgery (ERAS) protocol for orthopaedic patients. This was a multidisciplinary approach to reducing length of stay and improving patient experience and outcomes after surgery. At the time of our inspection the average length of stay on St Joseph's ward following hip and knee replacement was good at 3.4 days with 34% of patients being mobilised on the day of their surgery.
- World Health Organisation (WHO) surgical checklists were adapted from the national patient safety alert. WHO checklists for both breast and orthopaedic surgical procedures had been revised to ensure further checks were in place following recent never events, these documents were in draft awaiting final approval.
- Surgical site infection bundle was followed to include antibiotic prophylaxis, patient warming, hair removal and glycaemic control.
- Patients were reviewed on their sepsis management using best practice and evidence based guidance.

Pain relief

- Medical, nursing and therapy staff routinely assessed and managed patient pain. Patient pain was discussed at daily multidisciplinary team huddles.
- We observed patients pre-operatively being advised of pain management following their surgery and to ensure the availability of pain relief at home following discharge.
- The National Early Warning System enabled a pain assessment, records evidenced this was being completed consistently.
- Pain relief on wards was well managed. Patients were prescribed medication to manage their pain. This was either prescribed regularly or prescribed to be taken as needed. We observed nursing staff asking patients about their level of pain and if they required any pain relief.
- Patients told us their pain was well managed, and when requested, pain relief was given in a timely and effective manner.
- Staff in recovery felt the electronic prescribing was sometimes a slow process to access and record when patients required pain relief quickly.

Nutrition and hydration

- People's nutrition and hydration needs were assessed and met. The malnutrition universal screening tool (MUST) 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. The consultant would inform nursing staff if they could provide patients with water to drink, particularly if there were delays to the theatre list. Following operations patients were provided with fluid promptly, and their fluid intake was encouraged and monitored when on the ward.
- Nausea and vomiting was effectively managed for patients. Anti-sickness medication was administered to patients as required. Patient nausea and vomiting was discussed at the daily multidisciplinary team huddle.
- Protected meal times were in place to ensure patients were given the time, privacy and environment for eating and to encourage appropriate nutrition. Patients reported there was a wide selection of food options which were of a high quality.

Patient outcomes

- Between 1 January and 31 May 2017 the average length of stay for elective inpatients at St Michaels Hospital was 2.03 days. There were no emergency readmissions between 1 January and 31 May 2017. There were 23 routine readmissions.
- Data showed for surgical cases there was a 0.1% rate of deep vein thrombosis (DVT) at St Michaels Hospital between 1 January and 31 May 2017, with two cases of DVT in March 2017. There were no cases of pulmonary embolism in this time period.

- One orthopaedic consultant spoken with was proud of the efficiency of St Michael's Hospital in relation to early discharges of the patients, they felt this was positively affected by the co-ordination with the physiotherapists.
- Approximately a third of patients were mobilised on the day of their surgery. We observed this in practice with a patient who had undergone a total hip replacement. There was a whole team approach to rehabilitation. Nurses were being supported and trained to get patients out of bed, particularly to do this after 8pm when physiotherapists were not present.
- The physiotherapy department at St Michaels Hospital audited patient outcomes before and after they introduced extended hours. Twilight shifts working until 8pm were introduced in May 2016 and weekend working was introduced in August 2016. Data was captured up to December 2016. They found with their extended hours there was a 32.85% improvement of patients being stood on the day of their surgery due to staff availability. It was found that those patients who stood on the day of surgery continued to achieve their goals on average 0.62 days sooner than those who stand the day after surgery, and on average 0.68 days were saved on the length of stay.
- The physiotherapists discussed with consultants the optimal length of stay for orthopaedic patients. They agreed to aim for three days, which is in line with best practice, although patients could be discharged earlier if they had achieved the discharge criteria, or they could stay longer if it was required.
- The physiotherapy team delivered evidenced based treatment for joint replacement patients which helped to improve patient outcomes. A physiotherapy gym was present on St Josephs' inpatient ward, this included rehabilitation equipment which was adapted to enable post-surgery patients to use. Physiotherapists ran a joint school for orthopaedic patients, this was yet to be integrated into pre-assessment but work was being done to achieve this. Cold therapy was used for patients for post-operative recovery following knee surgery. This aims to improve patient outcomes by reducing pain and swelling and increasing the range of movement and is based on best practice. Physiotherapists completed a post-operative phone call two days following discharge for all patients, a further 14 day follow-up was completed if required.
- Patients were consented for participation in the national joint registry (NJR). The NJR collect information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor performance of joint replacement implants, and the effectiveness of different types of surgery.
- Service improvements were reviewed and improved through the use of audit. For example an audit was completed on the consultant and type of anaesthetic, against patient mobilisation on day of surgery. The results were presented at the governance group, fed back and staff have seen changes to the consultants practice as a result which improve patient care.
- Patient reported outcome measures from April 2015 to March 2016 (published in February 2017) considers the change in patients' self-reported health status for hip replacement and knee replacement. Data showed the trust adjusted average health gain for a knee replacement was better than the England average and for hip replacement the adjusted average health gain was similar to the England average.

Competent staff

- There was a commitment to training and education. Staff felt well supported to maintain and further develop their professional skills and experience. They were encouraged to develop their knowledge and skills and were supported in their continuous professional development. There were opportunities to attend external training and staff were able to apply for full or partial funding.
- Staff were encouraged and given opportunities to develop and take on specific roles. Link nurse roles were in place, to include tissue viability and infection control. Link nurses attended trust wide meetings to ensure they were competent in their role and provided with information and skills required.
- Theatre and ward staff were supported and managed. The ward and theatre staff had all received their appraisal. Staff informed us they felt this was a worthwhile process where their developmental needs were addressed and acted on. Nursing staff were being supported with their revalidation, however did find it difficult to find time in work time to complete this.
- 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.

- Resident medical officers were provided with a support structure. All resident medical officers had received an appraisal within the last year. A trust consultant hand surgeon undertook specific responsibility for resident medical officer support. A palliative care consultant provided educational supervision.
- A corporate induction and local induction were in place to create a framework in which all staff, whether temporary or permanent, 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, although some felt that the number of people attending the trust wide induction was too large to maximise the learning potential. New staff in the nursing team would work supernumerary, therefore shadowing staff, until they had all their competencies signed off.
- Student nurses were well supported in their placements. Staff were observed teaching the students and providing appropriate challenge to encourage their development.
- Poor or variable staff performance was identified and managed. Leaders provided examples of how they would identify this and the support they would provide to staff.

Multidisciplinary working

- Staff across all roles in the hospital were integrated and worked together to proactively deliver effective care and treatment. All necessary staff were involved to assess, plan and deliver the patients care and treatment. Staff worked together to ensure this care was co-ordinated.
- Daily multidisciplinary team huddles were held and attended by the ward team to include; nurses, therapists and the resident medical officer. These huddles focussed on current patient care and treatment and discharge plans.
- Early discharges were possible due to liaison and multidisciplinary team working with surgeons, nursing and therapy staff.
- There was consistent collaborative working between staff and staff from all levels and all professions informed us staff are always there to support and help each other. We heard of examples of nurses regularly assisting physiotherapists and resident medical officers helping to make beds.
- A system wide multidisciplinary approach was taken to the Enhanced Recovery After Surgery programme with staff on board to deliver standardised best practice care and reduce length of stay. This included therapy staff, nurses, consultants and resident medical officer. Some anaesthetists were not yet following the standardised procedure however staff told us about evidence which was being presented to them to encourage their participation.
- One orthopaedic consultant told us how they were involved with the enhanced recovery programme, and were due to present a paper with one of the physiotherapists on quality improvement, and addressing early mobilisation of hip and knee replacements.
- One consultant informed us of good working relationships within the theatre team. Surgery lists tended to run by day, for example a knee day, hip day, foot day. Staff said this streamlined patients well and meant there can be a team working ethos between the staff and patients to enable patient progression.
- Patients were treated holistically to ensure the correct staff provided care and treatment for the patient. For example an occupational therapist would be asked to support the patient following hand surgery. Staff said other teams responded quickly when requested.

Seven-day services

- Theatres were in use Mondays to Fridays with one list also being carried out on a Saturday morning. Consultants were on site when operations were in progress with medical cover being provided by the resident medical officers seven days a week 24 hours a day.
- Patients received regular therapy input from physiotherapists and occupational therapists. Physiotherapy services were provided seven days a week 7.30am – 8pm. Physiotherapists and physiotherapist assistants treated patients two or three times a day, dependent on patient need. Occupational therapists were available Monday to Friday 9am – 5pm.
- There was access to radiology on site Monday to Fridays. The radiographer was on-call at weekends.

- Pharmacy were based at Royal Cornwall Hospital but could be contacted as required, they were accessible by phone during working hours and by bleep out of hours.

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 weekly and pulled for the following week's theatre lists. 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. Discharge summaries were given to the patient and immediately sent to the GP. We reviewed seven completed discharge summaries, information included; diagnosis, treatment undertaken, further follow up or needs, medication to include changes and the wound.
- Information needed for on-going care was shared appropriately. Plans for discharge for complex cases were arranged at pre-assessment. Staff said they had a good relationship with onward care and could phone to handover patients when required. GPs were able to contact the ward directly or via the switchboard if they had any concerns or queries.

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. On admission medical and nursing staff spoke to the patient about their procedure and confirmed their consent. In theatre we observed the patient's consent form being checked by both the anaesthetist and operating department practitioner before beginning the procedure. We observed staff seeking verbal consent from patients before undertaking care and also ensuring patients were fully informed of the potential risks before treatment was undertaken.
- At pre-operative assessments consent was taken for the permission to share patient information with the National Joint Registry.
- Most staff were aware of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Mental Capacity Act and deprivation of liberty training was fully incorporated into mandatory training so staff knew what their responsibilities were and how to apply them within everyday practice.
- Staff had a good knowledge and understanding of the processes involved in determining whether a patient had capacity, how to gain adequate consent and their responsibilities surrounding this. Staff we spoke with told us if they had concerns about consent they would raise it with a senior member of staff or ask medical staff to review a patient's capacity.

Are surgery services caring?

Outstanding ☆

We rated caring as outstanding because:

- Patients spoken with continually gave us overwhelmingly positive feedback on the care and treatment they had received.
- The wards were inundated with thank you cards which sang the praises of the care staff provided in theatres and on the ward. This was also reflected in the high numbers of extremely positive comments submitted with the friends and family test.
- Staff put patient care at the forefront of everything they did. They took the time to interact with patients and provided care which was compassionate, supportive, and reassuring.
- Privacy and dignity was always respected to ensure patients received sensitive care and treatment.
- Staff communicated with patients clearly and ensured their understanding to keep them involved in their care. This was evident across all staff roles. Staff were able to provide additional support, recognising those individuals who required this.
- Staff understood the emotional support patients required and adapted their care and treatment to ensure patients were provided with this support. Anxieties were recognised and assurance was provided to patients.

- Staff consistently promoted patient independence and supported and encouraged patients to progress their own health and wellbeing through engaging in normal daily activities.

Compassionate care

- Feedback from people who use the service and those who are close to them was continually positive about the way staff treat people. There were positive results from the friends and family test. In June 2017 100% would recommend St Joseph's inpatient ward and 96% would recommend St Michaels day case ward. In May 2017 97% would recommend St Joseph's inpatient ward and 100% would recommend St Michaels day case ward. Similar results were seen for previous months.
- People felt staff went the extra mile and the care they received exceeded their expectations. Between January and June 2017 there were 342 comments from the friends and family test, of which 341 were extremely positive about the care and treatment received. Comments included; "everyone without exception has been extremely kind, patient and helpful", "fantastic care given at all times felt very confident about all aspects of care", "kindness and care was shown from the moment I entered the ward I cannot praise enough the care which I received", "the level of care has been exemplary. All the staff are both efficient and friendly" and "wonderful care and attention I cannot speak highly enough about the amazing people who looked after me".
- Patients spoke highly of the staff and were impressed with the care they had received. The relationships were highly valued by staff and promoted by the leaders. We spoke with 16 patients and three relatives and all were overwhelmingly positive about their care and treatment. Patients told us how staff provided compassionate and sensitive care and treatment. Comments included, ' nurses are very good', 'I would be happy to stay another month', 'It is like a hotel and I could be on holiday' and ' you could not get better care if you were the Queen'
- Throughout our inspection, we observed patients being treated with the highest levels of compassion, dignity, and respect. We saw all staff going the extra mile to support patients' personal and cultural needs. For example, patients told us how they respected their religious needs and ensured they could attend the quiet room for prayer.
- We observed good attention from all staff to patient privacy and dignity. We observed curtains being drawn when care or confidential discussions were taking place. Patients we spoke with told us they were always treated with dignity and respect.
- In theatre patients were being cared for with gentleness in a calm atmosphere. Dignity, privacy and confidentiality was maintained in a consistent manner. The atmosphere in recovery unit appeared conducive to effective recovery from surgery. The care provided was calm and quiet and everything appeared to be done in a timely manner. Practitioners were very confident, competent and caring.
- Care from the staff was delivered with kindness and patience. We observed a physiotherapist calmly and patiently assisting a patient whilst walking. They reassured the patient at all times and ensured they were comfortable with what was being asked of them.
- Patients reported to the hospital reception on the day of their surgery. We observed the receptionist dealing with patients and queries in a calm and welcoming manner. Smiling and happy to help in any way despite the busy environment. They provided the patients with clear instructions regarding where to go.
- We observed the interaction between a physiotherapist and a patient, the physiotherapist was reassuring, patient focussed and encouraging. They maintained dignity throughout treatment, for example considering if the patient wanted their dressing gown on.
- We observed patient call bells being answered quickly. When patients were brought to the ward from recovery nursing staff ensured the call bell was accessible and explained to the patient to call them if they needed anything. The wards aimed to answer call bells within two minutes.
- We observed a pre-operative assessment and the nurse was very quiet when talking to the patient to respect patient confidentiality. Questions were also asked sensitively. There was gentle touching of the patients arm to offer compassion.
- It was evident good relationships were built with the patient and their families, with a sense of humour to put people at ease. Staff checked how patients was feeling and continually reassured them.
- A level two care rounding intermittent observation was used for patients. At least every two hours it was recorded that patients were checked for their comfort, wellbeing, continence, pain and hydration. For example

ensuring the fluids and call bell are in reach, and assessing trips or hazards. Also checking with the patient they are comfortable and if they need anything. We saw this completed in the seven care records we reviewed.

- One patient on the ward was suffering with nausea and vomiting. During an episode of vomiting nursing staff rushed to the aid of the patient to provide care and immediately pulled the curtains to maintain their dignity.
- We saw staff respond quickly to an emergency call bell following a patient faint, staff pulled curtains immediately to maintain the patients dignity.
- Each 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 the month of May both wards had achieved 100% in each area, in the month of June 100% was achieved with the exception of St Michaels Ward 98% for A and R and 96% for E.
- There were a large number of thank you cards received which were displayed on both of the wards. All cards we looked at were complimentary about the staff and care received.

Understanding and involvement of patients and those close to them

- There was a strong, visible person-centre culture and patients were truly respected and valued as individuals, empowered as partners in their care. Patients were continually involved in their care and the decisions taken. In theatre patients were kept informed of the care and treatment they were receiving. Surgeons and anaesthetists visited patients in recovery to explain the surgery undertaken. 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 ongoing plans.
- Patients and relatives were encouraged to be involved in their care as much as they felt able to. One relative we spoke to who did not live in the same area as the patient commented how staff had arranged an earlier discharge time for them to give them the time to travel.
- We observed healthcare professionals introducing themselves and explaining their roles and responsibilities. Patients we spoke with said they were aware of who was involved in their care.
- Staff recognised when patients needed additional support. One patient told us that staff had recognised the impact that a problem with their hearing was having not only on their physical health but also their psychological health. Staff had taken the time to arrange an outpatient appointment within the hospital so this could be assessed and treated.
- Patients reported they were fully informed of discharge plans in place and these were adapted to the needs of the patients. Relatives were given time to ensure appropriate clothing and transport was arranged.
- Patients were given the ability to connect with family members. One patient we spoke with whose family lived far away and did not have a mobile phone reported they had been able to use the hospital phone when requested to contact family.
- Staff were aware that patient's treatment and needs were different. Some of the comments from patients we spoke with included, 'they treat me as an individual' and 'out of all the hospitals I would prefer to come here as you are treated as an individual, you are not a number or just part of a queue'.

Emotional support

- Staff recognised and respected people's needs and took in to account their personal, cultural, social and religious needs. Staff understood the impact the care, treatment or condition might have on the patient's wellbeing and on those close to them both emotionally and socially. We heard how staff had moved forward a patients operation time as they had recognised how anxious and worried they were and the impact waiting was having on this.
- Staff were kind and understood that patients needed home comforts. One patient we spoke with said, 'you are made to feel like you are at home as much as possible'.
- Patients were given the opportunity to ask questions and raise concerns. Staff responded in a timely and reassuring manner. Patients we spoke with said, 'they always come when you ring a bell' and 'nothing is too much trouble'.
- Patient care and support was not only limited to the condition patients were admitted for. One patient said

staff had understood their mental health concerns, they had ensured this was appropriately managed, and care and support was in place for when they were discharged.

- Patients were empowered and supported to improve their own health and wellbeing and maximise their independence. We observed patients being brought back to the ward who had spent some time together socialising in the garden so they could enjoy the good weather. Patients were very grateful for this opportunity and said it helped them feel more independent and enhanced their recovery.
- Patients who had undergone surgery were encouraged to mobilise around the ward independently when they were safe and able to do so. We observed a patient who was walking independently with crutches around the ward to improve their confidence, on two separate occasions members of staff praised the patient and encouraged them to continue this approach to their rehabilitation.
- We viewed numerous thank you cards that were displayed on the wards. All comments were positive. This included; 'I cannot put into words how much it meant to be treated so kindly and friendly', 'thank you for all the care you put into every patient', 'thank you for going above and beyond, I have seen first-hand your caring, devoted and very professional attitude and approach to others' and 'I felt wanted and cared for every second I was on your ward'.
- One patient told us 'the consultant and nursing staff have been very supportive to me.'

Are surgery services responsive?

Good

We rated responsive as good because:

- Theatre lists at St Michaels Hospital were not restricted by bed capacity and therefore there was good flow from theatres to wards.
- Surgical cancellations were low at St Michaels Hospital. Reasons for cancellations were reviewed regularly.
- The multidisciplinary team reviewed and planned discharge from point of admission to ensure patients were discharged timely.
- The referral to treatment time for the orthopaedic speciality was better than the national average.
- Orthopaedic patients were transferred from Royal Cornwall Hospital to St Michaels Hospital so patients could receive the benefit of the therapy team for their rehabilitation and ensure resources were used effectively at both sites.
- The hospital planned and delivered services in a way which took into account the needs of different people.

However:

- St Michael's Hospital was not being used to full capacity to help improve the flow across the trust. However, a business case was in place to increase orthopaedic surgery, so there was potential for improvement in the future.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was being used to inform how services were planned and delivered. Management and staff we spoke with all agreed the capacity of St Michaels and the number of surgical lists could be adapted or increased to reduce waiting times for patients across the trust, and ensure St Michaels was used to its full potential and capacity. A business case, driven by the hospital manager, was in place to increase the orthopaedic list from 80% to 95% by introducing weekend working and working until 8pm Monday to Friday.
- Services provided reflected the needs of the population served, however the ability for patients to choose this service directly was variable. Staff told us St Michaels Hospital is popular with patients and the local community, however via choose and book patients cannot specifically choose St Michaels as it comes under Royal Cornwall Hospital Trust.
- The facilities and premises were appropriate for the services that are planned and delivered. Staff were aware of the emotional needs of patients and adapted the environment to meet these needs. Patients undergoing breast care were situated in the bay closest to the private stairwell. This helped ensure privacy and dignity could be maintained. These patients were also allowed to have their relatives with them outside of visiting hours as staff recognised their need for additional support.

- The hospital has specific facilities to provide care for its patients. The therapy team provided a 'hip replacement school' in the therapy gym on the ward for patients undergoing hip replacements. These were provided prior to surgery and gave patients and carers or relatives the opportunity to prepare for changes post-surgery and become familiar with the environment. For example, patients were shown around the gym and given the opportunity to get used to using crutches.

Access and flow

- People were able to access care and treatment in a timely way for orthopaedic and breast surgery. 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 for orthopaedics, in which 80% of patients were seen at St Michaels Hospital, 71.3% achieved the 18 week RTT compared to 64.2% England average. The breast referral to treatment performance was measured against the national 62 day cancer target. Between April 2016 and March 2017 182 patients were treated, 92.3% achieved the target, 14 patients received care which breached the 62 day target.
- Services ran on time and people were kept informed if there was any disruption. There was good flow from theatre to wards and minimal delays to theatre lists. There were no restrictions to bed availability for the theatre lists and lists were able to start once the medical team had seen the patients.
- To minimise the risk of cancellations through patients not attending, patients were informed of their appointment date and time in advance. The majority of patients admitted to St Michael's Hospital for surgery were elective patients for breast or orthopaedic care. Patients would be sent a letter with the date of their appointment, if the date proposed was within three weeks, patients would be contacted by phone. Patients would also receive a phone call reminder seven days prior to their agreed appointment.
- Patients were admitted to the day case area, here they were reviewed and consented prior to preparation for surgery. Some theatre lists staggered admissions to reduce the patient waiting time prior to their surgery, but this was dependent on the consultant and the procedure. Following surgery day case patients would return to St Michael's day case ward and inpatients would move to St Joseph's inpatient ward. One patient did comment how this did not allow them to orientate themselves and meet staff on the inpatient ward. On both wards nurses were able to manage single sex bays.
- Theatre utilisation, timings and turnaround times were monitored and monthly data was reported and displayed for staff. 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 67% of sessions started on time and 92% finished on time or earlier, there was a mean start time of 09:18 and a mean finish time of 16:42. Turnaround between the patient being transferred to recovery and next anaesthetic start time achieving 10 minutes was at 71%.
- The trust provided us with monthly theatre utilisation data between December 2016 and May 2017 for each of the four theatres at St Michaels Hospital. Theatre utilisation ranged between 76.5% and 89.4%, on average the utilisation for theatres at St Michael's Hospital was 84.4%. However, data is negatively skewed (shows the figure to be lower than it actually is) because utilisation was calculated based on using theatres seven days a week. Therefore the utilisation is poor when considering the potential for full theatre usage seven days a week.
- The key performance indicator (KPI) tracker for St Michael's hospital reviewed activity on a weekly basis against available sessions in line with planned theatre capacity, Monday to Friday with one theatre on Saturday. Between April 2016 and March 2017 inclusive theatre utilisation was at 94%. Between the 13 full weeks from the week ending 9 April to the week ending 2 July 2017 there was a 93% utilisation against a hospital target of 98%. In this time period there was an average of 4.2 cancellations a week against a hospital target of three cancellations. There were a total of 54 cancellations for breast surgery, orthopaedic surgery, pain management and trauma hand surgery, of these 28 cancellations were patient related and 26 were hospital related.
- The KPI tracker also included the physiotherapy data. Data for May 2017 showed 33.8% of patients stood on the day of their surgery, achieving physiotherapy goals

in 2.2 days with a length of stay of 3.0 days. For the 66.2% of patients who stood the day after their surgery they achieved their physiotherapy goals in 2.9 days with a length of stay of 3.5 days.

- There were a low number of cancellations at St Michael's Hospital. Cancellations were monitored and if issues arose these were discussed at hospital board meetings. Information on cancellations was collected to look at the reason for cancellation and the amount of notice given. This data had been used to change practice to reduce cancellation rates. Changes included the introduction of triaging as well as increasing the validity of pre assessments from three months to nine months in line with National Institute of Health and Care Excellence guidelines.
- Lists were monitored using electronic systems, which could be reviewed by speciality to look at what is being delivered, cancelled and what is on the following week and weeks ahead against an activity trajectory. Weekly meetings were led by the associate director of theatres, anaesthetics and surgery, attended by directorate managers, to look at this information. Directorate managers could then be encouraged to work with bookers and clinicians to ensure list were completes and theatres well utilised.
- The multidisciplinary team planned and reviewed discharge consistently from admission to discharge. This aided the flow through St Michael's Hospital. We were told the time of discharge was variable, there was no bed capacity issues at St Michael's Hospital and therefore staff were able to be flexible to discharge patients at a time of day which met the patients' and family's needs. On discharge patients were provided with contact numbers for the surgeon's team in hours and the hospital or to contact their emergency GP out of hours.
- During our inspection there was capacity at St Michael's Hospital to treat more patients, bed spaces were available, therefore this capacity was not always utilised. This was due to the number of patients being dependent on the number of procedures completed in the four theatres. Bed occupancy data for St Michael's Hospital, based on 48 available beds was at 54.4% in April 2017 and 57.2% in May 2017. Occupancy was measured at midnight and therefore the data is negatively skewed (shows the figure to be lower than it actually is) as 24 beds were day case beds which were never used overnight.
- Patients under the care of the trauma and orthopaedic team were routinely transferred from Royal Cornwall Hospital to St Michael's Hospital postoperatively to continue rehabilitation following surgery. This was planned as part of the joint replacement pathway for those patients receiving surgery at Royal Cornwall Hospital and patients were expected to transfer on day two. All trauma and orthopaedic inpatients were considered daily for transfer to St Michael's Hospital to release capacity on the main site based on their current medical status and planned rehabilitation. All patients transferred to St Michael's Hospital received therapy input for rehabilitation, no patient was transferred to St Michael's Hospital solely for relieving bed pressures at Royal Cornwall Hospital. The aim of the transfer was to enable as many patients as possible to receive the benefit of the increased therapy team at St Michael's Hospital and ensure resource on both sites is used effectively. From the 1 January to 12 July 2017 194 patients were transferred from Royal Cornwall Hospital to St Michael's Hospital for rehabilitation.

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.
- If a patient with a learning disability or mental health issue elected for surgery at St Michael's Hospital, the multidisciplinary team would review them prior to admission to confirm requirements and ensure staffing levels appropriate to meet the patient's care needs. The hospital allowed family or carers to stay overnight should this be required. There was access to the trust learning disability link nurse who was based at Royal Cornwall Hospital. If patients were identified as requiring mental health support staff were able to refer them.
- Staff told us it was not common for patients living with dementia to be admitted to St Michaels Hospital. However, if a patient living with dementia was admitted

they would provide one to one nursing care to ensure their needs were met. The ward environment was dementia friendly with bays with colour coded doors, clocks for orientation and an assigned member of staff.

- Breast care patients were provided with continued support from diagnosis through to post operatively, this could be provided internally by clinicians and the breast care team. Patients could also be signposted for external support for example Macmillan Cancer Support.
- There was access to a family room for patients and relatives to spend some time as well as a quiet room available. The quiet room was furnished and could be used as a place of worship; however, it was furnished mostly for those of a Christian faith with limited things available for other faiths. There was a chaplaincy on site, and a chaplain could be requested if required. We were told about plans to relocate the place of worship and make it more appropriate to multiple faiths.
- Information leaflets were available for patients on the wards and included information on hip and knee replacements, post-surgery as well as more general information on things such as alcohol consumption. Although we did not see any leaflets on display that were in other languages or in large font for patients with visual impairments, these could be accessed if required.
- Staff were aware of the social needs of patients. We overheard arrangements taking place for a patient who was having difficulty with child care arrangements. Things were organised so the patient's surgery did not have to be cancelled.
- Patient independence was encouraged and patients were able to leave the ward, if stable, to go outside.
- Social assessments were completed for patients to ensure they had arranged transport for discharge and someone available when at home. Transport could be arranged for patients if this was required.
- The hospital regularly provided care and treatment to out of county transgender patients who were often very anxious. Staff in the pre-operative assessment clinic were provided with training to support transgender patients and meet their specific requirements.

Learning from complaints and concerns

- People's concerns and complaints were listened and responded to and used to improve the quality of care. There were very few complaints received for the surgical service at St Michael's Hospital. We were told management were proactive about complaints and dealt with the issue at the time, they were visible and therefore could resolve concerns locally and in a timely manner.
- Leaflets to inform patients of how to make a complaint were available on surgical wards, however they were amongst an abundance of leaflets and therefore were not easily identifiable. Patients and visitors we spoke with did not all know how to make a complaint or raise a concern, however they all reported they would feel confident in not only enquiring how to do this but also in raising the complaint.
- Practice had been changed following concerns or complaints being raised. We were informed that a patient had raised a concern about the large amount of information received prior to surgery and how this had not been manageable and was confusing. Following this, the hospital was in the process of forming specific patient guides for procedure which would contain essential information and links where other information could be found.
- There was a comments book present in St Michael's ward. However, there had been only two comments submitted in 2016. Both were positive.

Are surgery services well-led?

Good

We rated well-led as good because:

- The local leadership team supported their teams and promoted good quality care.
- There was an overwhelmingly positive culture at St Michael's Hospital across all departments and staff roles.
- There was a clear vision and strategy for surgical services at St Michaels Hospital, staff were aware and kept involved with progress and understood their roles in achieving this.
- There was an awareness amongst staff of the key risks for the hospital and departments and actions which were in place to mitigate risks.
- The St Michael's Clinical Programme Board was a platform to discuss how surgical services could be improved for the benefit of the patients, and provided an opportunity for staff involvement.

- St Michael's Hospital were actively seeking ways of improving their surgical services through external reviews and benchmarking. Work streams were in place to review how changes could be implemented for sustainability of surgical services.

However:

- There were financial restrictions to the vision and strategy for surgical services at St Michaels Hospital.
- The ward risk register we were provided with did not include the date the risk was opened and some risks had not been reviewed for two or more years. We were not provided with a risk register specific for theatres at St Michael's Hospital.
- Public engagement was limited to obtain views of patients to enable the service to be improved and developed.

Leadership of service

- The leadership within the service reflected the vision and values, encouraged openness and transparency and promoted good quality care.
- Leaders were visible and approachable. The ward sister and the theatre manager provided on site leadership, they were managerial and not clinically on the rota. There was a hospital manager and surgical clinical matron who worked trust wide, they were only on site at St Michael's Hospital approximately one day a week, however staff said they were contactable when not on site.
- The leaders understood the challenges to good quality care and identified the actions to address these. The ward sister and theatre manager were knowledgeable about the department, staff and implications of trust communications for the service. The departments appeared to be well organised and care was delivered in a calm and structured atmosphere.
- Trust wide the ward sister attended weekly sister meetings and the theatre manager monthly theatre manager meetings to ensure they were informed of trust wide issues and learning to enable them to share with the team at St Michaels Hospital.
- Staff said there was good visibility and support of breast and orthopaedic clinical directors as they were regularly at the site performing lists.
- The trust wide challenges and geography of St Michael's Hospital meant the visibility of the executive team was not as good as it could be.
- Staff felt the cascade of information was very good from the leadership team at St Michaels Hospital. They were regularly informed of performance, incidents, complaints, risks, and changes to practice.
- Staff shared positive examples of support from managers, managers were responsive in concerns or issues raised, and were adaptable to ensure staff well-being.

Culture within the service

- There was an extremely positive culture within the service. This was evident within the wards and theatres of St Michael's Hospital, across all staff roles. Staff felt the smaller hospital, and personal and friendly culture amongst staff, promoted a good atmosphere and environment, this benefitted the patient and staff had time to provide quality gold standard care.
- Staff said they felt respected and valued and that all staff were supportive and approachable. They felt their managers listened to them and were confident in raising any concerns or issues they had. Staff felt supported to challenge their peers and clinicians if this was required. We were told about examples where staff had raised concerns both in theatres and on the ward and how this had been supported and encouraged by managers as staff were doing the right thing.
- The culture was centred around the needs and experience of the people who used the service. When asked, staff were continually positive about working in the hospital and how patient care was at the forefront of everything they did. They said the atmosphere and approach of staff was one of team work and shared responsibilities. This was confirmed when talking to patients who were continually positive about their experience when at St Michael's Hospital.
- Action was taken to address behaviour and performance that is inconsistent with the vision and values of the organisation, regardless of seniority. Managers told us how they were supported to work with staff on their performance and encouraged to do this if performance was not up to standard. We were told of some recent examples of the performance management of staff and how this had been managed well with support from the human resources team and more senior managers.
- Managers we spoke with all spoke highly of the level of care and commitment of the staff within the hospital.

We heard how staff were willing to cover bank shifts if the hospital was short staffed and stayed on after their shifts on occasion if theatres or the wards were particularly busy.

- We received positive feedback from student nurses on the support they received during their placements.
- Staff and teams worked collaboratively and shared responsibility to deliver good quality care. This was evident through the team work between theatres, wards and outpatients, and within each team. The two wards had recently amalgamated staff, staff reflected on this positively and said they had integrated well. Theatre staff enjoyed the working environment of theatres, which they said was enhanced by the cohesive team spirit of colleagues.

Vision and strategy for this service

- There was a trust vision and values, staff were aware of these and they were displayed at St Michael's Hospital.
- There was also a clear vision and strategy for St Michael's Hospital surgical services. The vision was to increase elective orthopaedic surgery from 80% to 95%, this would be implemented through weekend working and extending Monday to Friday end times to 8pm. Further consideration was also given to the theatre lists and patients who could receive their operation at St Michael's Hospital. However, the implications of this was recognised by the management team, particularly with the desire to increase the complexity of patients and procedures at the hospital and the financial restraints. For example the requirement for increased medical cover and a high dependency unit if the admission criteria was changed to include more complex patients. A business case had been formed and was under review at the time of our inspection. This was being reviewed by the trust management group and clinical directors before a decision was made.
- Staff in all departments were aware of the vision and strategy for St Michael's Hospital. Monthly strategy meetings were held, chaired by the associate director of surgery and the orthopaedic clinical director. Staff who attended this meeting said the management team were open about plans and they felt this was an informed meeting. However, some staff were not aware this could be attended by all staff and felt it was a band six and seven meeting only.
- The local sustainability and transformation plan (STP) were being considered when reviewing the plans for the service going forward. The STP is formed from a partnership between NHS and local councils to improve health and care. Each area develops proposals built around the needs of the whole population in the area, not just those individual organisations.
- 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 Michael's 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 St Michael's Hospital regularly experiences locum anaesthetists.
- The pre-operative assessment work stream had 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 St Michaels 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.

Governance, risk management and quality measurement

- Governance responsibilities were clear within the governance framework for St Michael's Hospital. There were clear reporting routes and locally quality measures were reviewed and discussed.

- 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 St Michael's Clinical Programme Board was held monthly to discuss strategies, local quality measures, concerns and improvements. We reviewed meeting minutes. Discussions were held around the key performance indicator trackers, this was used to review the quality measures, this included capacity, utilisation, cancellations, length of stay and readmissions. We saw evidence the strategy and service improvements were discussed.
- Theatre department team huddles were held each morning, all team members and the theatre manager were present. Checks were made of any problems or issues for theatres.
- Safety briefings were held each morning on the inpatient ward to ensure staff were aware of any issues or risks.
- Departmental meetings were held on an adhoc basis for the multidisciplinary team, however staff said they were informed of relevant information via the management structures and email updates. The band six ward managers attended weekly meetings with the band seven ward sister.
- The breast and orthopaedic governance leads attended trust wide governance meetings.
- There was a trust wide systems meeting weekly at Royal Cornwall Hospital for information sharing and peer support.
- On site leaders were very clear of the risks and how these were mitigated. Risk registers were held for the hospital and escalated to the divisional and corporate risk register as required. We requested copies of the St Michael's Hospital risk register to cover wards and theatres.
- Risks for the wards at St Michael's Hospital were clearly detailed with mitigating actions. We were provided with a ward risk register which included 27 risks. However, we did find there was not a clear audit trail for adding and monitoring risks. We were unable to determine from this risk register when these risks were added, and although all were within their review date some had not been reviewed for two years or longer. We did see that there was alignment between recorded risks and what people told us was on their worry list. For example the concerns with no on site security.
- Risks for the theatres at St Michaels Hospital were not clearly reflected and recorded within risk registers. The theatre risk register which we were provided with was generic for the trust theatre and anaesthesia division. We therefore were unable to determine if risks were being identified and managed effectively specific to the theatres at St Michael's Hospital.

Public engagement

- Patient's views were gathered to develop services, however this was limited to friends and family tests. These were displayed on the walls of each ward. There were limited other ways in which patients views were obtained.
- Each surgical ward displayed a 'you said we did' board. This contained patient's compliments and concerns and the actions taken. This included a concern following the level of noise on the ward; actions taken and displayed included informing all staff, visitors and patients to keep noise to a minimum.
- Staff told us patients regularly left comments on the NHS choices website which were reviewed and could be used to improve services or be provided with confirmation of what was working well.
- The therapy team provided a quarterly patient survey where feedback concentrated on different themes in quarter.

Staff engagement

- Staff were engaged and involved in an informal basis through regular contact with their managers. Staff said they were confident to raise any concerns or feedback via their management structure.
- Staff were able to attend the monthly St Michael's Clinical Programme Board, however this was not well publicised to staff below band six level and some staff told us they were not aware they could attend to enable them to engage.

- Some staff attended 'listen in to action' events which were a trust wide initiative. The staff who attended found these events helpful. These events were held as a focus group to enable talking and ideas of innovation. These had been attended by the chief executive.
- Staff told us snapshot surveys were used trust wide, these were mainly based on the staff survey results.
- Positive feedback was regularly shared with staff and staff received the team talk newsletter to ensure they were kept informed.

Innovation, improvement and sustainability

- Through talking to management it was evident St Michael's Hospital was actively benchmarking and looking for improvements by comparing to similar hospitals and trusts. For example they visited an independent hospital who specialised in orthopaedics and looked at the ways of working to see how improvements could be made at St Michael's Hospital. Another example is how they have been working with a prosthesis supplier as part of a service improvement plan for hip and knee pathways. The supplier has reviewed the patient pathway and provided recommendations.
- The St Michael's Clinical Programme Board is a platform to discuss how things can be improved for patient experience and outcomes. For example it was discussed how patient experience could be improved through the use of one single document rather than numerous leaflets. This document would include all information, for example, expectations, exercises and discharge. This was based on an acute trust and will be tailored to reflect the St Michael's Hospital pathway.
- Physiotherapy and the multidisciplinary team are looking at the joint score before an operation. This will bridge the gap for patients from pre-assessment to the operation and ensure input from healthcare professionals. It will also provide patients with exercises ahead of their surgery to improve their outcomes. A working group has been set up to start in August 2017 to enable plans to be confirmed, check sustainability and involve the multidisciplinary team across the pathway.

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

St Michael's Hospital in Hayle is a registered location of Royal Cornwall Hospitals NHS Trust. It provides a range of outpatient services and an X-ray service.

We visited the service for one day and spent time in the general outpatient's area, X-ray department, the pre-operative assessment clinic and main reception.

There is one main outpatient department within St Michael's Hospital accommodating a number of outpatient services and a number of further departments/areas 'owned' by individual specialties for example the pre-operative assessment clinic.

Between July 2016 and June 2017 there were 26,799 outpatient appointments at St Michael's hospital.

St Michael's hospital has an X-ray department providing services Monday to Friday between the hours of 9am and 5pm.

Between July 2016 and June 2017 there were 14,868 diagnostic procedures (X-rays) carried out at St Michael's.

The service was last inspected in January 2016: Outpatient services were not inspected during the inspection.

Summary of findings

We rated this service as good because:

- Staff reported incidents and demonstrated knowledge of how to do this.
- The environments we visited were 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 appropriately.
- People's individual care records were stored securely in the outpatient's and X-ray service. The main reception area used computer records to book patients in when they arrived for their appointment the screen was not visible to patients and the paper clinic lists kept by the receptionist were kept covered so they could not be seen by patients.
- There were arrangements in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements.
- Staff were 100% compliant with their mandatory training.
- Staff received training to look after people in an emergency.
- The outpatient and X-ray services used relevant evidence based best practice guidance and standards to develop how services, care and treatment were delivered.

Outpatients and diagnostic imaging

- The outpatient services and X-ray department participated in local and national audits, benchmarking and peer review.
- 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.
- All staff we spoke with reported good multidisciplinary working between different departments and other Royal Cornwall Hospital Trust (RCHT) hospital sites.
- The outpatient services at St Michael's hospital ran Monday to Friday between 9am and 5 pm. There were no weekend or out of hours services.
- Staff in all outpatient services were able to access relevant information to ensure they provided the appropriate care and support to patients.
- Staff understood and respected patient's personal, cultural, social and religious needs.
- Staff showed a supportive attitude to patients. When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way.
- We saw 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 signpost people to external services who may be able to provide ongoing support.
- 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 for people with dementia, mobility problems, hearing difficulties and visual impairment may be given longer appointment times.
- There was and pay and display parking, with disabled spaces. There was a drop off area at the main reception as the car park was a short walk away.
- 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 via 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.
- Referral to treatment times were overall better than the England average. Once in the outpatient departments patients did not have to wait long before they were called in to see their clinician.
- There was information displayed and available about how to make a complaint or raise a concern.
- The local management team were well respected. They supported their teams and promoted good quality care. The departments we visited were well organised and had a calm feel.
- There was a very positive culture in all of the outpatient departments we visited.
- There was a clear vision for the general outpatient and physiotherapy areas which were being redesigned and refurbished.
- Staff felt informed about activity across the trust as a whole.
- Through a programme of audit and work streams areas for improvement were identified and changes implemented.
- Public engagement was ongoing and the hospital had a very active League of Friends.

However:

- Individual records of each prescription issued were not kept. This meant that prescriptions might not be traceable if a problem arose in the future.
- There was a potential for a breach of confidentiality in the pre-operative assessment clinic. It was accessible to the general public who may be able to access patient records if they were left unattended in the clinic.
- In the pre-operative clinic waiting room tiles had fallen from the roof on at least two occasions and as

recently as four weeks prior to the inspection. Staff told us the tiles have been replaced but no investigation had been carried out as to why they had fallen and there was no risk assessment in place
- There were no call bells in the general outpatient consulting rooms.

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 environments we visited were 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 appropriately.
- People's individual care records were stored securely in the outpatient's and X-ray service. The main reception area used computer records to book patients in when they arrived for their appointment the screen was not visible to patients and the paper clinic lists kept by the receptionist were kept covered so they could not be seen by patients.
- There were arrangements in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements.
- Staff were 100% complaint with their mandatory training.
- Staff received training to look after people in an emergency.

However:

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- There were no call bells in the general outpatient consulting rooms.

Outpatients and diagnostic imaging

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 and demonstrated knowledge of how to do this. Outpatient staff had no specific examples of recent incidents reported. One trained nurse described in detail the process for reporting and treating a needle stick injury, if one occurred.
- X-ray staff described three recent incidents that had been reported. They had been reviewed by the team leader and feedback about any learning was fed back during monthly audit meetings. There was access, via email, to minutes of the meetings for staff that were unable to attend the meetings.
- When things went wrong in the outpatients and diagnostics department reviews or investigations were carried out. Serious Incidents were investigated. There was one serious incident reported in St Michael's hospital outpatients departments in the 12 months prior to the inspection. It involved a set of patient notes being left in an unlockable drawer overnight and over a weekend. Actions were taken to discover who had left the notes in the drawer, this could not be established. All reception staff were reminded of the importance of maintaining patient confidentiality and locking notes away.
- 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.
- The imaging service ensured, if necessary, that exposures that were 'much greater than intended' were notified to the Care Quality Commission under IR(ME)R regulations or to Health and Safety Executive (HSE) under the ionising radiations regulations (IRR99) requirements.

Duty of Candour

- There had been no duty of candour notifications in the 12 months prior to our inspection. 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 needed to be taken and how to access the trust guidance on the process. We also saw a description of duty of candour displayed on notice boards within the main outpatients department.

Cleanliness, infection control and hygiene

- All areas we visited (reception, main outpatients, X-ray, pre-operative assessment clinic and the physiotherapy department) appeared clean and hygienic and were clutter free.
- Cleaning staff attended each area on a daily basis and followed a daily cleaning schedule. Outpatient staff told us senior staff and a supervisor from the external company, employed to carry out cleaning services, carried out regular walk arounds of the department to ensure the cleanliness of the department was maintained.
- Staff in the pre-operative assessment clinic told us their housekeeping staff were 'brilliant' and always put a lot of effort into ensuring the department was clean and hygienic.
- There were fabric privacy curtains in the pre-operative assessment clinic. Staff told us they were changed by the housekeeping staff every six months, although we did not see documentation to support this. There were fabric curtains in the changing cubicle in the X-ray department. It was not clear when these were due to be changed.
- We saw staff adhered to the trusts 'bare below the elbow 'policy and applied good handwashing techniques. There were hand-washing sinks available in all departments and consulting rooms. At each sink was also liquid soap, paper towels and pedal bins in line with good infection control practice. Hand hygiene compliance results for the main outpatient department for June 2017 were 100%. The results were displayed in patient areas.
- In the physiotherapy department hand hygiene audits were undertaken by patients using a brief audit form. They thought 10 observations were completed each month. The physiotherapists did not know if this was taking place as they don't see the results. If any

non-compliance is noted the physiotherapist's initials were added to the form and this was picked up by their manager. It was not clear who organised the audit and collated the results.

- Personal protective equipment (disposable gloves and aprons) was readily available in all departments and we saw staff using it appropriately.
- Ear, nose and throat (ENT) endoscopes used for internal examinations were cleaned thoroughly between each patient using a recognised process when there was no dedicated scope cleaner available. A consultant we spoke with said whilst this system did not follow ENT UK guidance it was accepted practice in satellite services. They said they felt the system in use was safe and it had been discussed with the trusts infection control team and sterile services department before being put into practice. There was a detailed procedure (signed and dated) for cleaning the endoscopes displayed in the room where the cleaning took place.
- Chairs in all the waiting areas we saw were in a good condition and had wipe clean surfaces.
- Although there was a cleansing gel dispenser on the main reception desk we did not see any patients using this in a half hour period that we sat at the desk.

Environment and equipment

- The physiotherapy department has curtained cubicles this meant that there was at times a lack of confidentiality. There was no independent treatment room with a door in the department. However the trust had signed off a redevelopment to redesign and improve the environment, to be paid for by the hospitals League of Friends.
- The main outpatient department was due to be redesigned and refurbished. Staff did not know if there was a designated start date for this yet.
- The corridor in the porta cabin area, where a number of different clinics were held, was very narrow. This meant there was no access for wheelchair users. Staff said if they were aware in advance that a patient was a wheelchair user they would make an alternative consulting room available for their consultation. There was no emergency call bell in the consulting rooms in the porta cabin. If the area was not manned for example when a staff member went to collect a patient it would be difficult for staff in the main outpatient area to hear if somebody was shouting for help.
- There were no call bells in the consulting rooms in main outpatient department. Staff were able to call for assistance and felt confident staff would be in earshot and respond to their call. There were call bells in the X-ray department and in the pre- operative assessment clinic.
- There was work ongoing to the patient's toilet on the day we inspected. The area was covered up and health and safety notices were displayed. There were directions to an alternative toilet although we heard a number of patients asking staff where to find the alternative toilet.
- There was access to a resuscitation trolley both in the main outpatients department and the pre-operative assessment clinic. 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 safe systems in place for managing general and clinical waste and clinical specimens.
- In the pre-operative assessment clinic there was unrestricted access from the waiting room directly into the clinic from which you could get to the main hospital and potentially access otherwise restricted areas. This also meant staff did not know who was in the clinic if they were behind doors or curtains dealing with a patient. Staff said this had made them feel vulnerable at times. Staff thought the trust were looking into providing a security keypad to the door from the waiting room but they had no idea when this was to happen.
- In the pre-operative assessment clinic waiting room, tiles had fallen from the roof on at least two occasions, and as recently as four weeks ago. On this occasion a patient had just left the area otherwise the tiles would have fallen onto them. Staff told us the tiles have been replaced but no investigation had been carried out as to why they had fallen and there was no risk assessment in place.
- Equipment was regularly maintained, calibrated and serviced in order to keep people safe. We saw stickers on equipment with dates of when the equipment had been checked or when it was due to be checked. All the ones we saw were in date.
- A red light was lit when the X-ray machine was being used to ensure people did not enter the room. Lead coats were available for staff and carers who may need to support a patient during an X-ray. These were visually checked for damage daily and were stored correctly.

Outpatients and diagnostic imaging

Medicines

- There were no medicines used or stored in the physiotherapy department, X-ray or the pre –operative assessment clinic. Medicines for example eye drops were used in the outpatient department. They were stored in cupboards or in a designated medicines refrigerator inside a locked room accessible only by department staff.
- The refrigerator temperatures were measured and the results documented daily. There were details of what to do if the temperatures fell outside of the accepted range. A trained nurse we spoke with told us they would remove the medicines from the refrigerator and ask one of the wards if they could use their refrigerator until theirs was back in use.
- Prescription pads (FP10) were used in the main outpatient department and were stored securely in a locked cupboard in a locked room. The department was issued speciality specific prescription pads. These were signed in when received. However, individual records of each prescription issued were not kept. This meant that prescriptions might not be traceable if a problem arose in the future.
- The outpatient departments we visited did not administer controlled drugs.

Records

- The trust had a mix of paper and electronic records; there remained a reliance on paper records across all of the outpatient's services. There were plans to improve the records management with the implementation of electronic records systems, but this was not yet available.
- People's individual care records were stored securely in the outpatient's and X-ray service. We saw evidence of this in all of the clinics we visited except for the pre-operative assessment clinic. The main reception area used computer records to book patients in when they arrived for their appointment. The computer screen was not visible to patients and the paper clinic lists kept by the receptionist were kept covered so they could not be seen by patients.
- The pre-operative assessment clinic documentation, including anaesthetic notes, was audited, and feedback given about their quality. Notes were locked away when the clinic closed. However, there was potential for a member of the public to walk through the clinic and access the notes trolley if it was left unattended at any time during clinic opening hours.
- People's individual care records we saw were accurate, complete, legible and up to date. We looked at six patient records from a selection of different outpatient clinics. All notes contained relevant contact details, a copy of the referral, test results and stickers highlighting allergies were visible.
- The first page of the computer record indicated any alerts for example if a patient was hard or hearing or poor sighted, had dementia or a learning disability. This alerted the receptionist who then approached the patient to meet their individual needs.
- The referral management team kept records of patients who had had their appointments cancelled or for who the referral was not suitable.
- There was a reliable system for ensuring medical records availability for clinics. This system was audited regularly. On average 2.5% of patients, across the 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.
- Radiography staff recorded a patient identity, following a three point identity check, justification for the X-ray to be carried out, the dose of radiation and the operators name prior to image been sent for checking.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements. All staff we spoke with told us they had received safeguarding training at level two. They said following initial training it was then part of the annual mandatory training package. The training included information about female genital mutilation and sexual exploitation. Staff described the process for making a safeguarding alert and felt their manager would support them in the process. Reception staff had enjoyed the training and described how it had helped them to recognise potential non-accidental injury in children.

Outpatients and diagnostic imaging

- The trust had a safeguarding lead nurse who was accessible, to staff across all sites, for advice and support.
- Radiology staff told us if they had safeguarding concerns they would approach the outpatient department manager for advice and support in making an alert.
- The booking team told us if a child missed an outpatient appointment they would be sent another appointment. If a child missed two appointments it would be escalated to their GP.

Mandatory training

- All staff we spoke with told us they were up to date with their mandatory training. Mandatory training included control of infection, manual handling and fire safety awareness. Staff said the training had been condensed into half a day, face to face, on an annual basis with a lot of online material to read prior to the training. Some staff felt this was effective and others felt they benefitted from more face to face training.
- Data received showed as of 30 June 2017 there was 100% compliance with mandatory training for all outpatient staff.
- Radiologists, in addition to the trusts mandatory training, had speciality specific training and updates to ensure they remained competent.

Assessing and responding to patient risk

- Risks to people who use the service were assessed and monitored. For example if they had poor mobility and therefore difficulty moving around the department and at risk of falling.
- Staff received training in basic life support and had access to emergency resuscitation equipment.
- There was an anaphylaxis (extreme and severe allergic reaction) box in the main outpatient department for use in the case of anaphylactic shock. In an emergency situation. Although medical staff working in the hospital would respond, a 999 call would be made as the patient may have to be transported to the acute trust for assessment and appropriate treatment.
- The resident medical officer at the hospital and nurses in charge carried the on call bleep to respond to an emergency resuscitation call. These bleeps were tested weekly to ensure they were in working order.
- In the pre-operative assessment clinic nursing staff completed a full patient assessment to identify their baseline condition. The assessment included past medical history, current medication, personal risks for example falls or pressure damage and a full range of observations and blood tests as required for the procedure they were being assessed for. This information was used to plan treatments and any special requirements the patient had prior to and post-surgery. This assessment included an assessment by an occupational therapist to assess if any equipment was needed in the persons home post-surgery to help them recover.
- There was good signage and information displayed in the radiation department waiting area informing people about areas where radiation exposure takes 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 a trust employed radiation protection advisor if necessary.
- There were notices about notifying the X-ray staff if a person was pregnant in the changing cubicles but not in the X-ray waiting area. Female patients were routinely asked if they were pregnant. We heard staff asking female patients this question.

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 department and physiotherapy told us there was 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 in the pre-operative assessment clinic reported challenges with their staffing levels. Trained nurses had support from one healthcare assistant and a part time administrator which meant they sometimes felt pressured when trying to see patients on time and provide a full and complete assessment. However all booked clinics were able to run. Radiographers told us staffing was sometimes a challenge as there were only two radiographers to cover the department and any X-rays required by the operating theatres. The physiotherapy department had recently recruited one physiotherapist and were continuing to advertise for one more.

Outpatients and diagnostic imaging

- There was occasional use of bank staff in the general outpatients department and no use of agency staff. Staff reported a very low turnover of staff in the outpatient departments.
- Staff used communication diaries to relay messages to staff on duty the following day or passed information to the relevant managers to disseminate to appropriate staff.

Medical staffing

- There were no resident medical staff in the outpatient departments at St Michael's hospital. 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 and no cover could be found.
- There was no use of locum medical cover.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents in the local area. The trust had a major incident plan with clear roles and plans specific for St Michaels Hospital. Key staff knew where to find and access the policy and the role and responsibilities they had in the event of a major incident. For example, in the event of certain emergency situations the hospital would take direction from the trust or the local ambulance service.

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 X-ray services used relevant evidence based best practice guidance and standards to develop how services, care and treatment were delivered.
- The outpatient services and X-ray department participated in local and national audits, benchmarking and peer review.
- 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.
- All staff we spoke with reported good multidisciplinary working between different departments and other Royal Cornwall Hospital Trust (RCHT) hospital sites.
- The outpatient services at St Michael's hospital ran Monday to Friday between 9am and 5 pm. There were no weekend or out of hours services.
- Staff in all outpatient services were able to access 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 their intranet. We saw relevant policies displayed in treatment rooms and staff offices. Policies and standard operating procedures were based on the relevant guidance depending on the speciality of the clinic for example cleaning of ear, nose and throat endoscopes.
- Local rules were available on the electronic governance system in radiology. 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 levels were updated every two years.
- The outpatient's service used National Institute for Health and Clinical Excellence (NICE) guideline for example 66/87, management of type 2 diabetes to identify and implement best practice. Ear, nose and throat (ENT) clinics used ENT UK guidance to support their practice.

Pain relief

- There was no formal pain assessment tool in use in the outpatient services and staff assessed patient's pain using informal methods, which included observation of the patient or direct questions about pain levels, during assessments or consultations.

- Staff demonstrated a good understanding of methods available to them for pain management. This included encouraging patients to ask their consultant or GP to provide them with advice and medication for their pain or to refer them to the pain clinic.
- There was no pharmacy on site so if a patient was given a prescription for pain medication during an outpatient consultation they had to go to the local chemist to have it dispensed.

Patient outcomes.

- The outpatient services and X-ray department participated in local and national audits, benchmarking and peer review
- 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 X-ray services. For example radiation dose audits, documentation and hand hygiene audits. Action was taken as a result of audits for example discussion about good handwashing techniques and the importance of completing all relevant documentation to ensure a seamless patient journey through the system.
- The physiotherapy department collected outcomes using the goal attainment scale (Kings College London verified outcome measure) this was a verified outcome measure for rehabilitation.
- There was no evidence of joint or treatment specific outcome measures used in the physiotherapy department.

Competent staff

- All staff administering radiation were appropriately trained to do so. Radiographers said they had access to speciality specific training. Some had attended the UK Radiology Conference which meant they were updated on the latest developments and best practice advice.
- There was a competency programme in place for radiographers which were reviewed annually at the staff members personal development review (PDR).
- 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 for the nursing and Midwifery Council.

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 facilitated continued professional development and multidisciplinary working with other colleagues.
- The physiotherapy department had a women's health physiotherapist and a paediatric physiotherapist attached to their department. They saw specialist patients and advised other clinicians as required.
- The physiotherapy department did not have any extended scope practitioners (these are physiotherapists with advanced skills who can assess, diagnose and treat complex conditions) but staff had good links to extended scope practitioners who worked in community settings. This enabled them to gain advice and support when it was necessary.
- Staff in the general outpatient department described good access to pharmacy and infection control services based at RCHT. They added they had good working relationships with visiting consultants who used the department.
- Staff in the pre-operative assessment clinic described good working relationships with the anaesthetists who worked at the clinic and staff from RCHT who used clinic rooms for ophthalmology clinics. They also worked with the breast care nurse and with community and adult social care services as required.

Seven-day services

- The outpatient services at St Michael's hospital ran Monday to Friday between 9am and 5 pm. There were no weekend or out of hours services.

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 X-ray staff had electronic access to diagnostic results and 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 patient arrived at the reception and were therefore able to quickly direct them to the correct seating area for the clinic they were attending.
- Notes were 'traced' 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.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated understanding of gaining consent and the implications under the Mental Capacity Act 2005 including patients subject to Deprivation of Liberty safeguards (DOLs).
- Staff said 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.
- Staff in the pre-operative assessment clinic did not complete any consent forms related to their surgery, with patients, as that was done at the time they saw their consultant and anaesthetist.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- Staff understood and respected patient's personal, cultural, social and religious needs.
- Staff showed a supportive attitude to patients. When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way.
- We saw 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 signpost people to external services who may be able to provide on going support.

Compassionate care

- We heard staff introduce themselves when meeting patients using the 'hello my name is..' Staff explained their roles and responsibilities as recommended in NICE QS15 patient experience in adult NHS services.
- Staff showed a supportive attitude to patients. When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way.
- Staff did everything possible to ensure that people's privacy and dignity was respected within the reception areas, outpatients departments and X-ray department. In the physiotherapy department, cubicles were divided by curtains which resulted in some consultations being overheard.
- We did not see any information about chaperones being available displayed in the outpatient departments. Staff said there was always one available when a patient or doctor asked for one however the lack of this information being displayed resulted in this not clearly being communicated.

Understanding and involvement of patients and those close to them

- We heard staff ensuring patients understood the information they had been given during a consultation for example the need for a blood test or surgery. Patients were given time to ask questions about their consultation. A letter, detailing relevant information, was sent to the patient and their GP following their outpatient consultation.
- We saw information about safeguarding people from abuse was displayed where patients would see it.
- A radiographer took time to explain to a concerned relative why an X-ray was not going to be suitable and a scan was more appropriate for their relative. We saw the relative visibly relax and fully understood the reasoning behind the decision.

Emotional support

- Staff considered the psychological needs of patients using their services and were able to provide support and signpost people to external services who may be

able to provide ongoing support. Staff alerted consultants if they felt patients needed emotional support as they may be able to refer to psychology or counselling services if necessary.
- Staff in the pre-operative assessment clinic told us how they recognised when a person needed emotional support and for example worked very closely with the breast care nurse.
- Staff in the pre-operative assessment clinic worked with transgender patients to ensure they felt informed and supported in the pre-operative phase of their journey.
- We saw patients were given the opportunity and time to ask questions during their consultations.

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 for people with dementia, mobility problems, hearing difficulties and visual impairment may be given longer appointment times.
- There was and pay and display parking, with disabled spaces. There was a drop off area at the main reception as the car park was a short walk away.
- 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 via 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.
- Referral to treatment times were overall better than the England average. Once in the outpatient departments patients did not have to wait long before they were called in to see their clinician.
- There was information displayed and available about how to make a complaint or raise a concern.

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.
- If patients were 'flagged' as having a hearing impairment, visual impairment, dementia or a learning difficulty they were given a longer appointment time if appropriate.
- In the general outpatients department there were toys available in one waiting area, for children who were waiting for appointments.
- There were toilets available for patient use in all outpatient departments. On the day of our visit the toilet in the general outpatient department and X-ray was out of use due to building work. There were signs redirecting patients to an alternative toilet further along the corridor.
- There was a café run by volunteers open most week days and vending machines that were stocked with snacks and hot and cold drinks.
- There was no parking near to the general outpatient, physiotherapy and X-ray departments but there was a drop off area so patients did not have to walk too far. There was a separate entrance for the pre-operative assessment clinic which was near to the car park. The car park was a pay and display car park and provided several disabled parking spaces.
- The outpatient departments were clearly signposted and there was a receptionist at the reception desk in the main entrance who directed people where to go for their appointment. There was not always a receptionist at the pre-operative assessment clinic but there was access to the waiting room and staff came to call patients in for their appointments.
- Information sent to patients prior to their appointments was available in different formats for example large print or alternative languages.
- There were leaflets available and given to patients to help explain more about their condition or what to expect when attending for surgery.

Access and flow

- Appointments were booked via a referral management service. They 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 and a letter sent to their GP explaining the reason for the rejection and any action or additional information required.
- Patients were 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.
- There was a cancellation policy that stated if patients missed two appointments they were referred back to their GP. This helped make sure flow was managed by trying to make sure appointments were not made for people who no longer needed them.
- The percentage of cancelled outpatient clinics (provider wide) were as follows: Cancelled within six weeks of date February 2017 - 4.68%, March 2017 - 4.82%, April 2017 – 5%, May 2017 – 3.23%; Cancelled over six weeks from date February 2017 – 10.22%, March 2017 – 11.60%, April 2017 – 17.40% and May 2017 – 16.19%. The trust stated - The main reason for cancellations over 6 weeks from date was annual leave. Of those cancelled within 6 weeks, the top reason is 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 own Clinic Cancellation & Additions Tool (CCAT).
- Between April 2016 and March 2017 the trust's referral to treatment time (RTT) for non-admitted pathways had been better than the England overall performance. The latest figures for March 2017, showed 97% of this group of patients were treated within 18 weeks versus the England 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 was longer than six weeks was similar to the England average.
- The trust told us there was no data available, trust wide, of the proportion of patients that waited more than 30 minutes to see a clinician or what percentage of clinics started late.
- We saw patients did not wait long before they were called in to see the clinician either in the general outpatient department of the X-ray department. One patient waited for 4 minutes another waited for 6 minutes.
- 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 and this was in line with the target for the service. 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. Approximately 350 patients a week were seen in the physiotherapy department.

Meeting people's individual needs

- The needs of different people, including those in vulnerable circumstances, were assessed during their outpatient appointment. This enabled plans to be put in place ahead of the next appointment or admission.
- We saw a patient arrive from the Isles of Scilly for an outpatient appointment. They were asked if they were flying back to the islands that day. The patient confirmed they were and the receptionist advised them to let the outpatient staff know so they could make sure they were seen on time and would be able to make their flight. However the patient did not tell any staff so they remained unaware the patient needed to be seen on time. Once staff realised the patient was seen on time and made their flight on time. Whilst it is good patient centred practice to consider the patients' needs in terms of travelling back to Isles of Scilly. There was no formal process for the receptionist to inform the outpatient department staff about the situation; it relied on the patient informing staff. When we mentioned this to the outpatient department manager they said they would look into a more formal system.
- If staff were aware that a patient had dementia or 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.
- We saw staff helping people with mobility needs move around the department.

Outpatients and diagnostic imaging

- Radiographers had equipment that allowed for patients to be X-rayed whilst standing, which for some patients with painful conditions or mobility issues was much more comfortable than getting onto a couch and lying down.
- Staff had access to translation services via a telephone service, if required.
- Leaflets were available in different formats for example large print and in a variety of languages, on request.
- Staff in the pre-operative assessment clinic were trained to support transgender patients who were being assessed for their surgery.

Learning from complaints and concerns

- There was information about how to make a complaint displayed and patient advice and liaison (PALs) leaflets available in the main entrance to St Michael's hospital. We did not see any displayed in the pre-operative assessment clinic, which had a separate entrance.
- We were told if patients had any concerns or complaints staff would deal with them at the time, if patients made them aware. This resulted in few formal complaints.
- Feedback forms and 'friends and family' questionnaires encouraged people to detail their concerns. There was 'you said, we did' information displayed in the department.
- There had been one complaint made about the outpatients department at St Michael's hospital in the 12 months prior to the inspection. It concerned the attitude of a consultant and lack of treatment. The complaint was investigated using the trusts internal complaints policy and guidance and was upheld.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- The local management team were well respected. They supported their teams and promoted good quality care. The departments we visited were well organised and had a calm feel.
- There was a very positive culture in all of the outpatient departments we visited.
- There was a clear vision for the general outpatient and physiotherapy areas which were being redesigned and refurbished.
- Staff felt informed about activity across the trust as a whole.
- Through a programme of audit and work streams areas for improvement were identified and changes implemented.
- Public engagement was on going and the hospital had a very active League of Friends.

Leadership of service

- The departments we visited were well organised, and although busy, the departments were calm and appeared efficient.
- Local managers were visible. We spoke with the outpatient manager who was very enthusiastic about their staff group and talked about the upcoming improvements to the department. They added that happy well supported staff gave a better service to their ''customers' – the patients.
- Staff were complimentary about their local line managers and directorate managers based at Royal Cornwall Hospital Trust. They said they felt informed about what was happening trust wide and at St Michael's hospital. They felt regularly informed about risks, performance and required changes to practice.
- Staff gave positive examples of how their managers supported them, were responsive to concerns and were proactive in ensuring the well-being of the staff group.

Culture within the service

- There was a very positive culture in all the departments we visited. Whilst they were all busy staff said working at a smaller hospital meant there was more of a feeling of providing a personal service to patients. 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.
- Managers we spoke with spoke very highly of the care and commitment of their staff within the outpatient departments.
- The culture was based around the needs and experience of the patients who used the services. When asked, staff were always positive about working in the

hospital and described how patient care was at the centre of everything they did. This was confirmed when talking to patients who were also positive about their experiences at St Michael's Hospital.

Vision and strategy for this service

- Staff were aware of the trusts visions and values and they were displayed at St Michael's Hospital.
- Staff told us about the planned redesign and refurbishment of the main outpatients department and physiotherapy department. They were really looking forward to having more space and areas that were more patient focussed.
- There was no reference to St Michael's hospital X-ray department in the clinical imaging annual business plan 2017-2019. We were therefore not aware of how old the equipment was and if it was on a replacement programme.
- 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

- Governance responsibilities were clear within the governance framework for St Michael's Hospital. There were clear reporting routes and locally quality measures were reviewed and discussed.
- Governance meetings were held monthly for each speciality (directorate) and fed in to the service divisional board. Speciality governance newsletters were disseminated to staff and included information on; speciality related incidents, directorate never events and serious incidents, risk and complaints. There was a trust wide systems meeting weekly at Royal Cornwall Hospital for information sharing and peer support.
- All of the outpatient departments showed us and told us about the audits they took part in, both locally and national audits**.** Outpatient staff spoke about the electronic system they fed audit data into. They said there was feedback from the system if any audits were below target levels, but that rarely happened within the department.
- On site managers were clear about their local risks and how these were mitigated. Risk registers were held for the hospital and escalated to the divisional and corporate risk registers as required.
- 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. They described discussions around dose audits and equipment calibration adjusted on site to reduce doses in line with Diagnostic Radiology Consultants guidelines.

Public engagement

- The hospital had a very active and supportive League of Friends who ran the café and had raised money to pay for the new physiotherapy department.
- The local population enjoy having the hospital in their town and had, over the years, attended meetings and events in support of the hospital.
- Patient's views about the general outpatient department were gathered via the 'friends and family test' questionnaire. Results were displayed in the department.
- The therapy team undertook a quarterly patient survey where feedback on different themes was for each time.

Staff engagement

- Staff told us they had seen members of the trusts senior management team at the hospital at times.
- Some staff attended the trusts 'listen in to action' events and found them interesting. These had been attended by the chief executive.
- Staff told us the trust used snapshot surveys, mainly based on the staff survey outcomes. Results of these surveys were made available to staff.
- Positive feedback was shared with staff.
- Staff said they received newsletters (Team Talk) monthly and update emails from the trust to ensure they were kept informed about trust activity and plans.

Innovation, improvement and sustainability

- The general outpatient and physiotherapy departments were being redesigned and reconfigured to provide a more up to date environment and facilities.
- A pre-operative assessment work stream has rolled out across specialities over the previous two years. This enabled information to be instantly available to booking teams booking pre-operative assessments. The clinical

triage process had been reviewed as to whether patients required a telephone call with nurses, a face to face appointment with a nurse or a face to face appointment with an anaesthetist. Through this process the trust had found the number of patients arriving for surgery and being found to not being suitable for surgery at St Michael's Hospital had reduced significantly. The work stream was 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 pre-populated from the electronic patient questionnaire and be available for subsequent assessments throughout the patient pathway.

Outstanding practice and areas for improvement

Outstanding practice

The structured and co-ordinated multidisciplinary team working in a nurse and therapy led unit ensured patients care and treatment was seamless. This aimed to and had achieved improving patient experience and patient outcomes. Seven day working and twilight hours of physiotherapy enabled the enhanced recovery after surgery programme to be delivered. Data showed an increase in standing and mobilising patients on the day of their surgery and reductions in the average length of stay for orthopaedic patients.

There was an exceptionally positive culture amongst the staff working at St Michael's Hospital with a sense of good team spirit. The happy and calm atmosphere enabled high standards of care to be provided to patients. Patients were overwhelmingly positive about their care and treatment they had received.

There was a very positive culture in all the outpatient departments we visited. Staff spoke of good teamwork and flexibility within the staff groups.

Staff across all of the outpatient departments we visited and 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.

Areas for improvement

Action the hospital MUST take to improve

- Ensure staff investigating incidents are aware of the current guidance and the framework for reporting never events and comply with trust policy. The trust must review the never event incident of wrong side anaesthetic block at St Michaels Hospital in November 2016.
- Carry out a risk assessment and consider a long term solution to the ceiling tiles in the pre-operative assessment clinic waiting room to reduce the risk of them falling from the ceiling again.

Action the hospital SHOULD take to improve

- Continue to review the security arrangements within the hospital, and seek feedback and confirmation from staff that they feel safe in their working environment.
- Ensure staff are checking and referring to the instrument list included with the set as part of the checking procedure in theatres during wound closure.
- Ensure medications are identified for return to pharmacy in a timely manner. Controlled drug expiry dates should be checked with the daily stock checks and patient own medication should be returned at the nearest point following discharge.
- Ensure chlorine tablets remain safely locked and are not accessible to patients and visitors.
- Review the use of fabric reusable curtains and their implications on infection prevention control within the hospital.
- Ensure staff mandatory and local training gaps are addressed and compliance achieves trust targets.
- Consider a formal process for clinical supervision to ensure improvements in nurse practice and reflective learning.
- The trust should ensure there are processes in place for induction and orientation when St Michaels 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.
- Continue to review the capacity at St Michael's 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.
- Have in place a system to identify each individual prescription issued so that a prescription could be traceable if a problem arose in the future.

Outstanding practice and areas for improvement

- Consider the security of the door to the pre-operative assessment clinic to prevent people being able to access the unit and the rest of the hospital without staff knowing and to maintain confidentiality of patient notes.
- Consider the need for call bells in the general outpatient consulting rooms.

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	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 the premises. The ceiling tiles, that had previously fallen from the ceiling, in the pre-operative assessment clinic waiting room had not been risk assessed and a long term solution put in place to prevent the tiles falling from the ceiling in the future.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to — (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Systems were not effective in assessing, monitoring and improving the quality and safety of the services provided.

This section is primarily information for the provider

Requirement notices

A missed never event was identified during the inspection. In November 2016 a wrong side anaesthetic block was performed at St Michael's Hospital. This was not declared as a never event because incorrect guidance was followed which was not consistent with the corporate policy.