

Royal Cornwall Hospitals NHS Trust

Quality Report

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

Ratings

Overall rating for this trust	Requires improvement	
Are acute services at this trust safe?	Requires improvement	
Are acute services at this trust effective?	Good	
Are acute services at this trust caring?	Good	
Are acute services at this trust responsive?	Requires improvement	
Are acute services at this trust well-led?	Good	

Summary of findings

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Summary of findings

Overall summary

Royal Cornwall Hospitals Trust is a medium sized teaching district general hospital trust providing acute, specialist and community healthcare to the people of Cornwall and the Isles of Scilly, serving a population of around 450,000. This population is often doubled when the area is visited by holiday-makers and tourists in the summer months. The trust provides services at three hospitals. These are the Royal Cornwall Hospital in Truro (known locally as Treliske Hospital), St Michael's Hospital in Hayle and West Cornwall Hospital in Penzance. There are approximately 750 beds across these three hospitals. The trust is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures; family planning; management of supply of blood and blood-derived products; maternity and midwifery services; surgical procedures; termination of pregnancies; treatment of disease, disorder or injury.

Last year the trust provided services to about 130,000 inpatients, provided 480,000 outpatient appointments and 73,000 people visited the emergency department at Treliske Hospital and the urgent care centre at West Cornwall Hospital.

To carry out this review of acute services we spoke to patients and those who cared or spoke for them. Patients and carers were able to talk with us or write to us before, during and after our visit. We listened to all these people and read what they said. We analysed information we held about the hospital, and information from stakeholders and commissioners of services. People came to our two listening events in Truro and Penzance to share their experiences. To complete the review, we visited all three hospitals with specialists and experts. We spoke to more patients, carers, and staff from all areas of the trust on our visits.

The trust had undergone a number of changes and improvements over the last few years, most noticeably at Treliske Hospital. This had included a new accident and emergency (A&E) department, which opened in December 2013. There had also been a change in

leadership of the hospital trust. Many staff told us these changes had been positive, and they felt the trust had improved and they were proud to work there. There was a high degree of respect for the executive team.

Many of the services provided by the trust were delivered to a good standard, but overall the trust required improvement. Patients received safe care and were treated with dignity, respect and compassion. Patient records were not being accurately completed on all wards. Records were not always being held securely. The trust was finding it challenging to plan and deliver care to patients needing surgical or critical care, both to meet their needs, and to ensure their welfare and safety. This was because of the pressures it faced in meeting the increasing demand for its services, combined with delays in patients being able to leave hospital when they were ready because of capacity issues in the wider community. The plans to improve in this area needed to include the trust's partners who share the responsibility, either as commissioners or providers, for the effectiveness of health and social care services. The trust had made a significant investment to increase the number of staff. While that work continued, the trust was managing shortfalls by using bank and agency staff.

Patients' records were at risk of being seen by people not authorised to do so. The pressures upon beds meant that patients' procedures were being cancelled, or they were not being cared for in the most appropriate environment or ward. At times, shortages of staff meant staff were not able to provide the best care at all times, records were not being completed, and vulnerable patients may not have had the additional attention they needed.

Staffing

The impact of the investment in recruitment and training had made a significant difference to the trust and had been a factor in the improvements that we saw and that staff and patients described. This work was ongoing and in the meantime some staff felt under particular pressure. We observed that these pressures were felt most keenly in the medical and surgery wards at Treliske hospital. At Treliske, some nurses we met said they did not have enough time to spend with patients; nurse managers said

Summary of findings

they were often fulfilling clinical shifts and not their managerial duties; nursing staff said training often had to be postponed if their area was short-staffed. The nursing staff shortages were covered by agency and bank staff. At West Cornwall and St Michael's Hospitals, we found that there were sufficient staff of an appropriate skill mix to enable the effective delivery of care and treatment. Staff at St Michael's, both nursing and allied health professional such as physiotherapists, told us that they were often moved to work at Treliske, and this was a concern to them. Patients told us that consistency of staff was important to them. They said it was good to have the same staff on duty during your stay, and felt that this meant they had better and more consistent care. There were many, very positive comments from patients regarding their care from across the trust.

Cleanliness and infection control

The hospitals were clean. We observed good infection control practices among staff. Staff were wearing

appropriate personal protective equipment when delivering care to patients. At West Cornwall and St Michael's Hospitals information about infection control, including the use of hand gel, was clearly displayed, alongside gel dispensers throughout all areas. Infection rates were low. At Treliske Hospital we were concerned about the distribution of hand-wash gels, and instructions for people, patients, visitors and staff to ensure their hands were clean and they used sanitising gels appropriately. There was not enough provision of hand-gel at the entrances to wards and units in all places.

The number of patients with a catheter who got a urinary tract infection was higher than the average for England in the majority of the last 12 months. The number of MSRA bacteraemia infections and c. difficile infections attributable to the trust were with the acceptable range for a hospital of this size.

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of services.

Are services safe?

We found the services at the trust were safe however some improvements were required. Patients were protected from the risk of abuse. Incidents were mostly reported appropriately, and there was evidence of learning from them to improve care. Examples of improvements included the learning from never events in theatres and around pressure area care. (Never events are largely preventable patient safety incidents that should not occur if preventative measures are taken.) There were reliable systems, processes and practices in place to keep people safe who worked within the hospitals and across the trust.

The board and senior team had a focus on safety as demonstrated in interviews and board minutes. Staff at all levels described the focus on safety and referred to it as a priority. Staff felt able to raise concerns when they felt operational pressures, such as shortages of staff, had an impact on safety. The trust monitored safety at ward, specialty, divisional and trust level. The trust responded to risks and there was evidence of how plans for individual patients were changed in response to changing needs. The trust had anticipated and planned for problems relating to safety; for example, using additional funding for winter pressures to open the Frailty Assessment Unit.

Some patient notes were not accurate or complete, which could mean that there was not appropriate information available to plan care or judge if a patient's condition was improving or deteriorating. Staffing levels had increased and while recruitment continues, bank and agency staff are employed to deal with shortages. Despite this, the staff working in medical and surgical wards at Treslike hospital felt under pressure at times. This has been recognised and the trust was continuing to actively recruit staff.

Requires improvement



Are services effective?

Patient care and treatment was effective in most areas of the trust. Outcomes for patients were good and the trust performed well when measured against similar organisations. National guidelines and best practice were applied and monitored, and outcomes for patients were good overall. Both national and local audits were undertaken to monitor care, and outcomes and action plans were implemented where required to improve care. Staff worked in multidisciplinary teams to co-ordinate care around a patient. Staff were supported to be innovative and develop their clinical skills. Most mandatory training and appraisals were on track to be completed annually.

Good



Are services caring?

Patients were treated with dignity, respect and compassion. During our inspection we observed that almost all staff were caring, and patients confirmed this, saying also that staff were considerate, treated them with

Good



Summary of findings

kindness and respect, and that they felt safe. Patients and carers coming to the maternity and children's services said staff were caring and kind. A&E staff were praised for their kindness. Staff in the critical care team provided outstanding emotional support. There was an exceptional service provided by staff in the surgical team, for people with learning disabilities who might be scared about coming to hospital. We found people with learning disabilities were cared for well in other parts of the hospital. Children and their parents were kept involved with decisions and care planning. The care given to people at the end of their life was caring and sensitive.

People who came to our listening events had varied views about the care they received. Most people who contacted us outside of the hospital visits, but not all, were concerned about poor care and their experiences. Some described excellent care and compassionate staff.

Are services responsive to people's needs?

The trust planned to provide services to meet the needs of the people they served. Treliske and West Cornwall Hospitals were very busy, with around 95% of available beds in use, while St Michael's Hospital had less than 50% of beds in use. At Treliske Hospital, the high occupancy level, particularly in medical and surgical beds, was having an impact on the quality of care, and on the trust's ability to be responsive to people's needs. The lack of beds in parts of the hospital caused delays in the A&E department. There was sometimes pressure on maternity services, leading to women giving birth to their babies on the antenatal ward. The critical care unit was not meeting discharge targets, as there were sometimes no beds available into which to move patients who were recovering. Because of this, and other bed pressures, some surgical procedures were cancelled, and responsive care was complicated by medical patients being admitted to surgical wards due to shortages of beds on medical wards.

Patients were sometimes also delayed in their discharge into community care, because this was not being arranged in good time with, and by, other providers. The hospital was cancelling too many operations, and in some circumstances, there were inadequate facilities to consult with patients, which was causing further delays. The improvements required to ease the pressure on the trust needed to involve partners in the wider community to help manage the impact of the increasing number of people seeking treatment and the delays in people leaving the hospital.

The trust supported vulnerable patients well to ensure care was delivered in their best interests. Aspects of the care for people with learning disabilities were innovative and effective.

The trust had taken action to improve the way that complaints were handled. A complaints review panel identified and shared wider lessons from complaints. Changes had been made to processes and procedures following complaints and improvements in the timeliness of responses was seen.

Requires improvement



Summary of findings

Are services well-led?

The trust was well-led. The leadership and management of the trust had a clear vision and a credible strategy to deliver high quality care to patients. Some improvements were needed to deal with the challenges caused by the difficulties in moving patients through and out of hospital, and this would require working with partners and commissioners, so that needs were understood and planned for across the system. There were actions that the trust could take itself, in terms of planning service delivery and discharge. Many staff spoke about the executive team with respect and enthusiasm. Many staff from across the trust, working in a range of roles, talked about the difference that the Chief Executive had made over the past two years. There was a sense of energy and optimism, and improvements in engagement with staff. Staff talked about improvements in communication, and some staff said they felt they were encouraged to speak up and contribute their ideas. Staff were supported by their peers and managers to deliver good care and to support one another. Staff said they felt proud to work at the trust, and were included and consulted about plans and strategies. The trust identified areas where improvements could be made, and organised work-groups and experienced staff to address them.

Most wards were well-led, although the leadership on a few wards was not addressing the poor record-keeping, and some staff were unclear about their roles and responsibilities.

Good



Summary of findings

What people who use the trust's services say

The trust was rated about the same as other trusts in the 2012 Adult Inpatient Survey, while falling below other trusts in its performance around privacy and dignity in the emergency department, and in the availability of hand-washing materials. It performed just below the national average in the inpatient Friends and Family test,

but well above the national average for the A&E department. The hospital trust was ranked better than other trusts in 29 out of 69 questions in the 2012/13 Cancer Patient Experience Survey, and only worse than other trusts in 2 of the questions.

Areas for improvement

Action the trust **MUST** take to improve

- The trust needs to ensure patient records are accurate and complete in relation to their care and treatment. Patient records must be held securely.
- The trust needs to plan and deliver care safely and effectively, to people requiring emergency, surgical and critical care, to meet their needs and ensure their welfare and safety. This planning needs to involve the trust's partners to ensure that pressures and shortfalls in capacity are managed across the wider community.

Action the trust **SHOULD** take to improve

- There was a mismatch between the bed occupancy data and the reality of how busy Treliske Hospital was. Accurate information on the movement of patients through the hospital, the availability of beds, and on the issues contributing to the delays in people leaving hospital, was needed.
- The recruitment of additional staff and the planned use of bank and agency staff has been successful to date. This needs to continue to address the pressures that staff are feeling in the medical and surgical wards at Treliske.
- There were issues with the management of processes related breaches of the four hour waiting time target in A&E and the percentage of patients being termed as "clinical exceptions", which was significantly higher than the national average.
- Some wards were not as clear in their development as others. Staffing and support was needed for the stroke and elderly care wards.
- Identified shortcomings with hand hygiene were being addressed, but needed further work to be effective.

- Departments needed to ensure they had sufficient equipment at all times. Both A&E and theatre reported equipment being moved or used elsewhere in the hospital, and this causing risks and delays.
- Staff reporting of incidents was improving, but response to reporting, and the culture around it being used as a threat by some staff, needed addressing.
- The use of the World Health Organization (WHO) surgical safety checklist had improved, but required more attention until it was being used with full compliance.
- There were at times difficulties, due to the availability of either beds or midwives, transferring women from the antenatal ward to the delivery suite. This had resulted in some women labouring and delivering their babies on the antenatal ward. This had implications for the levels of staff support provided to them, and not meeting women's choices regarding their birth plan. For example, a woman could not have an epidural on the antenatal ward.
- Care for young people in the designated unit stopped at the age of 16, and new patients aged between 16 and 18 were cared for by adult services.
- The succession planning for key members of the critical care team, or effective cover for when they were not working, meant that the outreach service did not fulfil its potential.
- There was a risk to the IT systems in critical care from only having one experienced member of staff to provide back-up support and expertise.
- Privacy, dignity and confidentiality for some patients were not always being achieved.

Summary of findings

Action the trust **COULD** take to improve

- More work could be done to improve the care for people with dementia.
- Administration needed to be reviewed, to understand why patients were dissatisfied with the service they received in relation to appointments.
- There were concerns about the risk of unauthorised entry to St Michael's Hospital out of hours, which could put patients and staff at risk.
- Staff at St Michael's Hospital had concerns about how staffing levels in relation to the variable dependency of patients. They felt this was not well understood by senior managers.
- Staff at St Michael's Hospital were often moved to work at Treliske Hospital, and this was causing concern.
- Some staff at St Michael's Hospital felt disconnected from the rest of the trust.
- There was no single accommodation with ensuite facilities at St Michael's Hospital.
- Bed occupancy at St Michael's Hospital was less than 50%.
- The layout of the outpatients department at West Cornwall Hospital was not well suited to modern day healthcare.
- In the out patients department at St Michael's Hospital there was dust at high levels, such as high window sills, which could pose a risk of infection.
- Patient privacy and dignity could be comprised in the recovery wards at St Michael's Hospital and West Cornwall Hospital, due to lack of screens and curtains, and the effectiveness of portable space dividers.
- Clinical training arrangements were not well developed at St Michael's Hospital and West Cornwall Hospital.

Good practice

- The respiratory and oncology wards were recognised for their services. They were innovative and had strong leadership which created good outcomes for patients.
- The new A&E department was providing improved observation of patients, and improving their privacy, dignity and confidentiality.
- The stroke service in A&E was recognised for its pathway and delivering good outcomes to patients.
- The development of the Frailty Assessment Unit was providing elderly patients with the support they needed. The enthusiasm and interest of the staff was evident and felt positive for patient care.
- Staff were caring and hardworking, and supportive of the hospital as a whole. There was a strong sense of an improving service.
- Staff were encouraged to be innovative and improve their skills.
- There were good outcomes for patients in critical care. Mortality rates were below the national average.
- Staff spoke highly of their colleagues and management. There was good support and a strong team spirit within the trust.
- Many staff were experienced, caring, compassionate, and champions for their patients.
- There was an outstanding and innovative service provided from a theatre team for people with learning disabilities needing care and support.
- The new surgical service and merged division was evolving and settling down. The critical care unit and new theatres in the Trelawny Wing were designed and built to a high standard.
- Staff were proud of the care and treatment they provided to patients.
- Patients were positive about the care and treatment the nursing staff provided to them and/or their children.
- Staff worked well between teams.
- Consent and support for people who needed help to make decisions for others was done well.
- Patients spoke highly of the mammography service and dermatology.
- The Cancer Patient Survey in 2012/13 delivered exceptional feedback for services at the trust.

Overall rating:

Requires improvement



Royal Cornwall Hospitals NHS Trust

Detailed findings

Hospitals we looked at:

Royal Cornwall Hospital, Treliske, Truro; St Michael's Hospital, Hayle; West Cornwall Hospital, Penzance

Our inspection team

Our inspection team was led by:

Chair: Dr Sheila Shribman, recently retired National Clinical Director for Children, Young People and Maternity at the Department of Health, and consultant paediatrician. Non-executive director at Guy's and St Thomas' NHS Foundation Trust.

Team Leader: Mary Cridge, Head of Hospital Inspections, Care Quality Commission.

The team of 28 included CQC inspectors, managers and analysts, consultants and doctors specialising in emergency medicine, obstetrics and gynaecology, and oncology, a junior doctor, nurses specialising in children's care, theatre management, cancer and haematology, and community health, patient and public representatives, and experts by experience. Our team included senior NHS managers, including a medical director and a director of operations in the acute and community sector.

Background to Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospitals Trust is a medium sized teaching district general trust providing acute, specialist and community healthcare to the people of Cornwall and the Isles of Scilly, serving a population of around 450,000. This population is often doubled when the area is visited by holiday-makers and tourists in the summer months. The trust provides services at three hospitals with approximately 750 beds. These are the Royal Cornwall Hospital in Truro (known locally as Treliske Hospital), St Michael's Hospital in Hayle and West Cornwall Hospital in Penzance. The trust is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures; family planning; management of supply of blood and blood-derived products; maternity and midwifery services; surgical procedures; termination of pregnancies; treatment of disease, disorder or injury.

Treliske Hospital has a 24-hour emergency department and maternity service. Last year the trust provided services to

Detailed findings

about 120,000 inpatients, had around 500,000 outpatient appointments and 73,000 people visited the emergency department and urgent care centre at West Cornwall Hospital.

The Royal Cornwall Hospitals NHS trust has teaching-hospital status as part of the Peninsula School of Medicine and Dentistry. The trust employs around 5,200 staff, most who work at the Treliske Hospital in Truro.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Royal Cornwall Hospitals NHS Trust was considered to be a medium risk-level service.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew about the trust. We carried out announced visits on 21 and 22 January 2014. During our visits we held focus groups with a range of staff in the trust including nurses below the role of matron, matrons, allied health professionals, junior doctors, student nurses, consultants and administration staff. Staff were invited to attend drop-in sessions. We talked with patients and staff from areas of all three hospitals, including the wards, theatres, outpatient departments and the A&E departments. We observed how people were being cared for, and talked with carers and/or family members. We reviewed personal care or treatment records of patients. We held two listening events where patients and members of the public shared their views and experiences of the location. Unannounced visits to all three hospitals were carried out on Saturday 25 January 2014.

Are services safe?

Summary of findings

We found the services at the trust were safe however some improvements were required. Patients were protected from the risk of abuse. Incidents were mostly reported appropriately, and there was evidence of learning from them to improve care. Examples of improvements included the learning from never events in theatres and around pressure area care. (Never events are largely preventable patient safety incidents that should not occur if preventative measures are taken.) There were reliable systems, processes and practices in place to keep people safe who worked within the hospitals and across the trust.

The board and senior team had a focus on safety as demonstrated in interviews and board minutes. Staff at all levels described the focus on safety and referred to it as a priority. Staff felt able to raise concerns when they felt operational pressures, such as shortages of staff, had an impact on safety. The trust monitored safety at ward, specialty, divisional and trust level. The trust responded to risks and there was evidence of how plans for individual patients were changed in response to changing needs. The trust had anticipated and planned for problems relating to safety; for example, using additional funding for winter pressures to open the Frailty Assessment Unit.

Some patient notes were not accurate or complete, which could mean that there was not appropriate information available to plan care or judge if a patient's condition was improving or deteriorating. Staffing levels had increased and while recruitment continues, bank and agency staff are employed to deal with shortages. Despite this, the staff working in medical and surgical wards at Treslike hospital felt under pressure at times. This has been recognised and the trust was continuing to actively recruit staff.

good, and the surgical division performed well against the measures they use for safety and quality. The performance of individual consultants was reviewed at trust level, and the results showed results in line with, or better than, national averages. Staff there described the continual focus on safety. The A&E department had clear policies and protocols in place, and there were daily safety briefings. The maternity unit provided safe care to pre and post natal women. Children received safe care throughout the trust. There were clear protocols and appropriate equipment in place in outpatient's clinics to support safe care.

Where historical issues of safety had arisen, for example, with an individual gynaecologist, the trust had responded robustly and had worked transparently with partners and commissioners.

There were sufficient staff with appropriate skills to deliver effective care and treatment for most of the time. The trust had vacancies and was recruiting. Bank and agency staff were employed in a planned way to meet shortfalls. Many staff regularly worked beyond their set hours.

Some patient records had not been fully or accurately completed, and this posed a risk to those patients. We found gaps in the monitoring of regular checks to prevent skin pressure damage. Some records were inconsistent and unclear about the use of equipment and the number of staff needed to move a patient.

Learning and improvement

The trust was able to demonstrate that investigations of patient safety incidents, including investigations into the competency and practice of clinicians, were undertaken against a clear framework, that the lessons were shared, and had an impact on practice and service delivery. Independent reviews had been commissioned appropriately. An example of this was the recent Review of Cardiac Services undertaken by NHS England. The findings endorsed current good safe practice, and influenced developments and improvements.

There was clear evidence of learning from three never events which had occurred between December 2012 and November 2013. (These are largely preventable patient safety incidents that should not occur.) Two of these had occurred in Treliske Hospital and related to a patient having a hip replacement and was fitted with a wrong component and a patients with two scars had the wrong scar excised. The other never event occurred at St Michael's

Our findings

Safety and performance

We found the services at the hospital were safe however some improvements were required. There was a good record of measuring performance across all the service areas. The performance of surgeons at the hospitals was

Are services safe?

Hospital and involved a patient having an elective knee replacement being given on of the component of the prosthesis for the wrong side. Audits of compliance with the World Health Organization checklist showed improvements, and where 100% compliance had been achieved, auditors were rotated to prevent over-familiarity with the process.

Staff in some areas described how the learning from issues in other wards and services was fed back to them by their divisional manager. Staff were encouraged to report concerns about safety using the incident management system, and said that they received feedback if they requested it. Some staff were less clear about this, and some said that they did not always get feedback on specific incidents that they had reported.

Systems, processes and practices

There were systems and processes in place for reporting safety concerns, and these were in line with national guidance. The monthly multidisciplinary service and division meetings provided a forum for the discussion of performance and safety issues, as well as wider issues impacting on safety, such as staffing and resources. The Board had a focus on safety, and executive and non executive directors were directly involved in assessments of safety.

Monitoring safety and responding to risk

A programme of risk-based audits was undertaken, and the findings were used to improve patient safety. Audit results were prominently displayed in the corridors of wards and departments, for patients, staff and visitors to see. These included audits on hand hygiene, safe storage of medicine, methicillin-resistant staphylococcus aureus (MRSA) screening, cleaning care of intravenous lines, and falls. Action was taken as a result of audit outcomes; examples of this included the provision of training and the replacement of equipment.

Anticipation and planning

Patient safety and the anticipation of risk played a key part in planning. There was evidence of effective planning at the level of individual patients, with risks being assessed, and care being planned to avoid and mitigate risks. Early warning systems were in place for rapidly deteriorating patients.

Safety considerations impacted on strategic decisions and plans. Examples included increased consultant hours on the Medical Assessment Unit, the design and opening of the Frailty Assessment Unit, and the expanded A&E department at Treliske Hospital.



Are services effective?

(for example, treatment is effective)

Summary of findings

Patient care and treatment was effective in most areas of the trust. Outcomes for patients were good and the trust performed well when measured against similar organisations. National guidelines and best practice were applied and monitored, and outcomes for patients were good overall. Both national and local audits were undertaken to monitor care, and outcomes and action plans were implemented where required to improve care. Staff worked in multidisciplinary teams to co-ordinate care around a patient. Staff were supported to be innovative and develop their clinical skills. Most mandatory training and appraisals were on track to be completed annually.

Our findings

Using evidence-based guidance

The trust had a process in place to identify, implement and monitor relevant legislation, current and new best practice, and evidence-based guidelines and standards. National guidelines and best practice were applied and monitored. Staff had a good awareness of mental capacity issues, and where a patient lacked capacity to make particular decisions, that decision was made in their best interests.

Performance, monitoring and improvement of outcomes

The trust participated in national clinical audits, reviews of services, and benchmarking. For example, the trust had taken part in a number of national audits related to breast surgery, which included BASO - The Association for Cancer Surgery, the National Mastectomy and Breast Reconstruction Audit (NMBRA) and the Breast Cancer Clinical Outcome Measures (BCCOM) Project. No concerns had been highlighted in these audits. Staff in the oncology, renal and respiratory services were proactive and creative in developing the services they provided.

Mortality rates were reviewed at trust level, and within divisions and services. A recent external review of the effectiveness of this arrangement was favourable. Overall mortality rates for the trust were within normal ranges. The mortality rates on the critical care unit were low compared with national levels.

Performance in the surgery service was good in some areas, but needed improvement. Too many sessions in theatre were not being used, and operations were being cancelled because of bottlenecks elsewhere in the trust caused by lack of intensive care or ward beds. Some operations were cancelled or started late due to equipment not being available as expected.

Staff, equipment and facilities

External reviews, including the NHS England Review of Cardiac Services, had commented on the quality and dedication of staff. Some staff were concerned about the available flexibility to increase staffing levels when the dependency and needs of patients on a ward increase. Most staff had received an appraisal in the last year. Staff had access to training and continual professional development. Staff described the support they got from their colleagues and managers. Facilities varied across the trust. In some places recent investment in buildings and equipment had provided very effective environments in which to deliver care. Examples of this included A&E and critical care facilities at Treliske Hospital. In some places, the age and lay out of the facilities were not ideal, such as the outpatient's clinic at West Cornwall Hospital. Where facilities were not ideal, staff had worked to mitigate any risks to the effective delivery of care.

Multidisciplinary working and support

Patients and staff across the trust described good multidisciplinary team working, and observations supported this. Staff and patients commented on the very positive way that staff in A&E worked with colleagues from other parts of the trust. There was an excellent stroke pathway. Mental health specialists and elderly care nurses attended A&E to support the assessment and treatment of patients. Staff from the medical and surgical teams worked well together to co-ordinate the care for patients. Staff from the learning disability team worked as part of multidisciplinary teams as needed. This had a positive impact on the care given. Patients said they were kept informed and were supported as they moved between different services.

There were arrangements in place to support partnership working with other health and social care providers and commissioners. These arrangements did not appear to be fully effective, given the increased demand for services experienced by the trust, and the difficulties experienced in supporting patients to leave hospital in a timely way.



Are services caring?

Summary of findings

Patients were treated with dignity, respect and compassion. During our inspection we observed that almost all staff were caring, and patients confirmed this, saying also that staff were considerate, treated them with kindness and respect, and that they felt safe. Patients and carers coming to the maternity and children's services said staff were caring and kind. A&E staff were praised for their kindness. Staff in the critical care team provided outstanding emotional support. There was an exceptional service provided by staff in the surgical team, for people with learning disabilities who might be scared about coming to hospital. We found people with learning disabilities were cared for well in other parts of the hospital. Children and their parents were kept involved with decisions and care planning. The care given to people at the end of their life was caring and sensitive.

People who came to our listening events had varied views about the care they received. Most people who contacted us outside of the hospital visits, but not all, were concerned about poor care and their experiences. Some described excellent care and compassionate staff.

Our findings

Compassion, dignity and empathy

Patients were made to feel safe and comfortable, and were treated with compassion, dignity and empathy while they received treatment and personal care. In many places across the trust, we observed a good rapport between staff and patients. Patients told us that staff were patient and kind to them, and that they trusted them to deliver care. There were some isolated incidents where privacy and dignity were compromised, and where we felt staff were not talking to each other, or about a patient, in a respectful way. The trust had an overall score of five stars out of five stars on NHS Choices. Across the three hospitals, the positive themes were cleanliness, dignity and respect, staff co-operation and same-sex accommodation. The negative themes included communication, care and security out of office hours.

Involvement in care and decision making

Patients, and where appropriate their relatives and carers, were involved in their care, and were able to participate in decisions about their care in an informed way. Patients told us they had been involved and included in their treatment, and had been asked to give consent. This was supported by observations and reviews of patient records. The data from the Adult Inpatient Survey 2012 showed that the trust performed on a level with other trusts when people were asked about how much information about their condition or treatment was given to them.

Trust and communication

Staff developed trusting relationships with patients through good communication with them and their relatives. Staff were aware of, and understood the requirements of, the Mental Capacity Act 2005, and the action that they should take if they had concerns about a patient's ability to give informed consent. Translators were available, and this ensured that patients whose first language was not English were supported to understand their situation, and they were supported to make decisions about their care. There was also support available to people who had difficulties with hearing and vision. Patients said that staff were open, honest and sensitive.

The trust website was not as informative as it might have been in terms of information about the different services. Information was available throughout the trust, and patients were given relevant information about their continuing care when they left the hospital.

Emotional support

Patients received the support they needed to cope emotionally with their treatment and hospital stay. Patients said that staff recognised that they were all different and needed different levels of support. The trust had a group of learning disability liaison nurses who provided support to patients, and worked with staff in different areas to ensure that needs were taken account of in the planning and delivery of care. Staff working in intensive care told us that they were encouraged to be open and honest with patients, and to help them cope with their stay in hospital. Comments from patients and relatives were very positive about the support they received.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The trust planned to provide services to meet the needs of the people they served. Treliske and West Cornwall Hospitals were very busy, with around 95% of available beds in use, whilst St Michael's Hospital had less than 50% of beds in use. At Treliske Hospital, the high occupancy level, particularly in medical and surgical beds, was having an impact on the quality of care, and on the trust's ability to be responsive to people's needs. The lack of beds in parts of the hospital caused delays in the A&E department. There was sometimes pressure on maternity services, leading to women giving birth to their babies on the antenatal ward. The critical care unit was not meeting discharge targets, as there were sometimes no beds available into which to move patients who were recovering. Because of this, and other bed pressures, some surgical procedures were cancelled, and responsive care was complicated by medical patients being admitted to surgical wards due to shortages of beds on medical wards.

Patients were sometimes also delayed in their discharge into community care, because this was not being arranged in good time with, and by, other providers. The hospital was cancelling too many operations, and in some circumstances, there were inadequate facilities to consult with patients, which was causing further delays. The improvements required to ease the pressure on the trust needed to involve partners in the wider community to help manage the impact of the increasing number of people seeking treatment and the delays in people leaving the hospital.

The trust hospital supported vulnerable patients well to ensure care was delivered in their best interests. Aspects of the care for people with learning disabilities were innovative and effective.

The trust had taken action to improve the way that complaints were handled. A complaints review panel identified and shared wider lessons from complaints. Changes had been made to processes and procedures following complaints and improvements in the timeliness of responses was seen.

Our findings

Meeting people's needs

The trust understood the different needs of the community that it served, and this included an understanding of the impact of year-round tourism in Cornwall. The trust used this information to plan and design services. The trust demonstrated that it had worked with commissioners, GPs and other providers to ensure that care was co-ordinated to meet people's needs. These arrangements were not working as effectively as they could be. The year-on-year increases in demand for medical and surgical services indicated some mismatch between the level of activity being commissioned, and the actual demand for services.

There was a mismatch between the bed occupancy data and how busy Treliske Hospital was in reality. This was having an impact on the quality of care and on the trust's ability to be responsive to people's needs. The lack of beds in parts of the hospital caused delays in the A&E department. Since April 2013, the A&E department had met the government's four-hour target for 95% of patients to be seen and discharged, in just one month; it was just short of it in three months; and fell below it in four months (December 2013 data was not complete). There was sometimes pressure on maternity services, leading to women giving birth to their babies on the antenatal ward. There were approximately six women per month labouring and, or, delivering on the antenatal ward. The critical care unit was not meeting discharge targets, as there were sometimes no beds available into which to move patients who were recovering. Due to this and other bed pressures, some surgical procedures were cancelled, and responsive care was complicated by medical patients being admitted to surgical wards due to shortages of beds on medical wards. Patients were sometimes also delayed in their discharge into community care, due to it not being arranged in good time with, and by, other providers.

The chaplaincy service was available to people of all faiths and none. There were appropriate arrangements for single-sex accommodation on the wards. The availability of rooms for private conversations varied at the different hospitals and in the different services, but in all places both staff and patients told us that space was made available when needed.

Are services responsive to people's needs?

(for example, to feedback?)

Vulnerable patients and capacity

Patient's needs were met at each stage of their care, including when people were in vulnerable circumstances, or lacked the capacity to communicate their needs. Staff spoken with had undertaken appropriate safeguarding training and records confirmed this. They were aware of the Mental Capacity Act 2005 and the implications of this in order to protect patient's rights. Through a review of the records we saw that staff had assessed patients' mental capacity for making individual decisions; this included the recording of who was involved in the decisions and how the decision had been made. Staff were aware that patients had to be reassessed for each decision, and that they may have the capacity for some, but not all decisions.

Access to services

Access to services was determined by the availability of beds. When the number of beds was limited, and when admissions were planned and predicted, the trust considered whether to open additional beds, known as escalation beds. There were no escalation beds in use at the time of our inspection. The trust also cancelled operations because of lack of beds. In the eight-month period from March to October 2013 an average of 10% of operations were cancelled.

There were some issues with access to different services across the trust. For example, there had been significant problems with the ophthalmology department, resulting in a serious backlog of patients awaiting appointments. The trust was aware of this issue and it was being monitored at board level. A new ophthalmology unit had been opened in February 2013. Action plans were in place, and the trust had reported some success in reducing the waiting times for patients. We saw from trust data that cancelled operations in ophthalmology had reduced to low levels in the last three months.

Leaving hospital

Patient's needs and wishes were taken into account, so they were ready to leave hospital at the right time, when they were well enough, and with the right support in place. Some patients were delayed in leaving hospital because appropriate support packages, of care at home, or care

home beds, were not available at the time that they needed them. The trust had some nursing posts focused on arranging discharges, and staff and patients found this very effective. Care coordinators and social workers were also involved in daily ward rounds to help with the planning and liaison of care outside hospital. Patients gave examples of how they had been involved in these discussions, and had been supported to make decisions. Patients were discharged with helpful information.

The Adult Inpatient Survey 2012 said the hospital met national targets around discharge. Results for patients being given enough notice about when they were being discharged, and not being delayed more than four hours, were in line with expectations.

Learning from experiences, concerns and complaints

The trust captured patient feedback. This included results from the Friends and Family test, complaints and comments, patient experience groups, and the trust CARE (Communicate, Assist, Relieve, Encourage) campaign. Action had been taken to increase the responses received from patient surveys; for example, the survey forms used in children's services had been redesigned, were brightly coloured and in a child-friendly format.

The trust had taken action to improve the way that complaints were handled. A complaints review panel identified and shared wider lessons from complaints. Changes had been made to processes and procedures following complaints. Examples of this included changes to documentation around decisions, and improvements in keeping patients property safe when they were moved between wards.

Patients knew how to make complaints if they were not satisfied with their care. Leaflets and information about how to complain were seen throughout the trust. Themes and trends from complaints were reviewed at specialty meetings, and areas of concern were escalated. Learning from complaints was fed back to staff through ward meetings and newsletters.

Are services well-led?

Good



(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust was well-led. The leadership and management of the trust had a clear vision and a credible strategy to deliver high quality care to patients. Some improvements were needed to deal with the challenges caused by the difficulties in moving patients through and out of hospital, and this would require working with partners and commissioners so that needs were understood and planned for across the system. There were actions that the trust could take itself, in terms of planning service delivery and discharge. Many staff spoke about the executive team with respect and enthusiasm. Many staff from across the trust, working in a range of roles, talked about the difference that the Chief Executive had made over the past two years. There was a sense of energy and optimism, and improvements in engagement with staff. Staff talked about improvements in communication, and some staff said they felt they were encouraged to speak up and contribute their ideas. Staff were supported by their peers and managers to deliver good care and to support one another. Staff said they felt proud to work at the trust, and were included and consulted about plans and strategies. The trust identified areas where improvements could be made, and organised work-groups and experienced staff to address them.

Most wards were well-led, although the leadership on a few wards was not addressing the poor record-keeping, and some staff were unclear about their roles and responsibilities.

areas where service level strategies were evolving; for example, the surgery division had been through a significant reorganisation and not all risks had yet been addressed. The significant risk to the quality and safety of services presented by the pressure on the beds in the trust had not been fully addressed at the time of the inspection.

The geographical position of the trust meant that patient choice was limited and that in order to improve any public service in the peninsula required the support and sign up of all the key stakeholders in the area.

Governance arrangements

There was a coherent and integrated governance framework across the trust. These arrangements ensured that responsibilities were clear, quality and performance were regularly considered, and problems detected, understood and addressed. The arrangements linked services across the different hospitals. For example, the urgent care centre at West Cornwall Hospital was part of the division that included medicine, emergency department and West Cornwall Hospital. The division was led by a Divisional Director, Divisional Manager and Divisional Nurse. There was a monthly emergency department clinical governance meeting, which looked at both clinical and operational issues. Messages and learning from this meeting was cascaded to all staff through department meetings, information on notice boards, and discussion at handovers.

In some places, there had been significant changes in the way in which services were organised, and the governance arrangements had not been changed to reflect that. For example, the surgical division had recently evolved from a merger of the surgery, trauma and orthopaedics division with the theatre and anaesthetics division. This change was still very recent and governance procedures still reflected the previous arrangements. Each specialty in departments had a named governance lead, which was usually a consultant or associate specialist. The newly merged division now had an appointed administrator, and a standardised format for specialty meetings had been developed. There were monthly governance newsletters shared with staff which included: the risk register, incident updates, and patient safety and experience.

Ward staff showed us the monitoring arrangements and feedback about ward performance. Clinical governance meetings were held, and incidents, complaints and concerns were identified. The trust risk register identified

Our findings

Vision, strategy and risks

The leadership and management of the trust had a clear vision, and a credible strategy to deliver high quality care to patients. There were clear plans for the development of the organisation. Staff at all levels told us they knew there were historical problems in the organisation, but they all felt improvements were being made. They told us they were proud to work in the hospital and felt included in the developments taking place. Staff told us there had been a real move to patient-focused quality care. Staff at all levels were optimistic for continued improvements. There were

Are services well-led?

Good



(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

the most serious patient safety risks, and those breaching waiting time targets or good practice guidance. Ward staff meetings were held when staff received feedback and could discuss monitoring results. Senior management clinical governance took place to review all areas of care provided.

Leadership and culture

There was a sense that the Board had settled down, after a period of turbulence during 2013 when the chair and three non-executive directors had resigned. Since then, an experienced chair had been appointed and the vacancies on the Board, both executive and non executive, had been filled with candidates who were regarded as strong. The senior medical leadership, and staff throughout the trust, spoke of the effectiveness of the executive team. Staff we met at a number of wards or focus groups said the Nurse Executive (sometimes referred to in the NHS as the Chief Nurse or Director of Nursing) provided good support, leadership and mentoring to the nursing team throughout the hospital. Staff in West Cornwall Hospital told us that they had recently had more engagement with the executive team. They mentioned the last visit by a non-executive director, how they had received written comments back after this visit, and that the issues raised were being addressed and monitored.

Staff said they were well supported. New staff said they had been made to feel welcome, and there was a planned and prescriptive induction to follow. Staff we met said they would not have any hesitation about reporting poor care or other concerns to their line manager or senior management. Medical and nursing staff were dedicated and committed to providing good patient care, and to improving care. They told us communication was good and this promoted change.

There was a disconnect between the staff survey results for the trust, and the enthusiasm and passion that was observed during the inspection, and communicated in focus groups and staff drop-in sessions. Some staff told us that they were cynical after many years of change at the top of the organisation, but that they recognised that things were different now.

Patient experiences, staff involvement and engagement

Patient views and experiences were taken into account in the delivery of services, and staff were involved and engaged. Information about the performance of the ward

or department against a range of measures was displayed at the entrance to wards and in corridors. These displays were visible to staff, patients and visitors, and helped to provide a culture of openness. The displays were titled “How are we doing?” and “Patient experience”. This included information on the Friends and Family test, feedback from patients, and quality and safety information; for example, results from audits of hand hygiene, safe storage of medicines and number of falls and pressure ulcers.

Staff told us there was effective team-working across departments and all grades of staff. Patients we spoke with found the staff team to be approachable. A patient told us that they had been able to have a second opinion from the medical team when they had further concerns to discuss, regarding the medical care which had been initially provided. Staff told us how they were engaged with the development of, and decisions about, strategy. An example of this is how the end of life strategy was presented to the trust’s Governance Committee in October 2013, before being taken to a ‘Listening into Action’ event to hear the views of clinical staff in December 2013. The final revised strategy took account of both staff and patient views.

Learning, improvement, innovation and sustainability

The Board and the Executive team encouraged staff at all levels to invest in their learning and development. There was a Board Development programme in place which assessed and addressed individual and overall Board development needs. Staff at all levels, in all services, and at all hospitals told us that learning and improvement was a priority for them and for their managers. There were times when training and development activities were cancelled or postponed when there were shortages of staff.

The trust’s relationship with the Peninsula Medical School was good. Junior doctors and student nurses were very positive about the quality of teaching within the trust, and the support they received. The General Medical Council reported that the trust was mostly similar or better than expected in results from the National Training Scheme Survey for doctors.

The trust encouraged staff to look beyond Cornwall for their learning. The trust had looked at service delivery in Ireland and Scandinavia to inform their thinking on the

Are services well-led?

Good



(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

development of services. The trust had invited organisations such as NHS England and Salford Royal NHS Foundation Trust to work with them in the review and development of particular issues, such as infection control.

Staff we met said they felt encouraged within their departments to be innovative. The critical care team said they were able to attend national conferences, and the hospital hosted the regional annual intensive care conference in 2013. Staff we met said they felt encouraged within their division to learn and improve. Nursing staff

said they did sometimes feel isolated from some national training. A consultant anaesthetist told us the trust enabled them and colleagues to attend professional development courses and national conferences, and gave them time to travel and stay overnight when needed. Staff were aware of external reviews that had taken place; for example, the review of cardiology services in 2013. Staff described the actions that had been taken following this review, and the improvements that have been made to cardiology services.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>The provider had not ensured that patients were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each patient which should include appropriate information and documents in relation to the care and treatment provided to each patient.</p> <p>This is a breach of Regulation 20(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>The provider had failed to ensure patient records were kept securely at all times.</p> <p>This is a breach of Regulation 20(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</p> <p>How the regulation was not being met: Patient records on Tolgus and the Trauma wards were incomplete in relation to recent observational rounds. There was conflicting and missing information in patient records in relation to pressure-ulcer assessment and management, and in care plan records or nursing notes. On Phoenix ward and Wheal Agar ward risk assessments, monitoring records and care plans were not all fully completed, and were not explicit in how risks were to be managed and care was to be provided. This placed patients at risk of not receiving the care they needed.</p> <p>Patient records at West Cornwall Hospital were not always kept up to date, which risked a patients care or condition deteriorating without the written evidence for staff to compare the patient's signs and symptoms. It was not clear if care had been given and the documentation signed retrospectively or not.</p>

Compliance actions

Patient records on the Surgical Admissions Lounge, the Frailty Assessment Unit, Wheal Fortune, Wheal Rose, Fistral, Polkerris and the Neonatal Unit were stored in areas that were not secured, and at times were unattended by staff.

Regulated activity

Diagnostic and screening procedures

Regulation

The provider had not ensured that patients were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each patient which should include appropriate information and documents in relation to the care and treatment provided to each patient.

This is a breach of Regulation 20(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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Regulated activity

Treatment of disease, disorder or injury

Regulation

The provider had failed at times to plan and deliver care to patients needing emergency care, surgical procedures and intensive care to meet their needs and ensure their welfare and safety.

This is a breach of Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

How the regulation was not being met: Too many operations were being cancelled or delayed due to a shortage of ward beds. Patients were not always being discharged, or admitted to critical care, in a timely way due to a lack of available beds in other areas of the hospital, meaning that patients were not discharged from a critical care bed in good time. Some patients were not getting enough time in critical care due the pressure to release bed space. Operations were starting late as patients were not able to meet their theatre team at the optimum time to gain consent and to ensure the surgical lists were on time. This was due to some admission wards not having enough space to carry out these confidential conversations. Theatre equipment was sometimes in the wrong place, delaying the start of some operations. Some patients were spending too long in the recovery wards, or moving to other areas at the hospital to recover, which may have compromised their safety. The accident and emergency department were regularly missing waiting-time targets due to the lack of available beds to discharge people into effectively.

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Compliance actions

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Regulated activity

Regulation

Surgical procedures

The provider had failed at times to plan and deliver care to patients needing emergency care, surgical procedures and intensive care to meet their needs and ensure their welfare and safety.

This is a breach of Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

How the regulation was not being met: Too many operations were being cancelled or delayed due to a shortage of ward beds. Patients were not always being discharged, or admitted to critical care, in a timely way due to a lack of available beds in other areas of the

Compliance actions

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